Research Project Report
(C85RES)

University of Lincoln

Institute of Work, Health and Organisations

Implicit Theories in High Secure Male Child Sexual Offenders with a Mental Disorder

Karyn Mannix

Thesis submitted in partial fulfillment of the requirements of the University of Lincoln for the degree of Doctorate in Clinical Psychology

September 2010

Table of Contents

Appendices

Tables

Abstract

There is an abundance of research on the aetiology and maintenance of child sexual offending and many factors have been proposed as being influential, including distorted cognitions. These are the focus of this study, in particular, the underlying implicit theories thought to generate them. Ward and Keenan (1999) hypothesised that child sexual offenders hold five distinct implicit theories which account for the majority of their cognitive distortions, and which they use to make predictions about the meaning of children's behaviour and underlying desires and intentions. These include *Children as Sexual Beings, Nature of Harm, Uncontrollability, Dangerous World* and *Entitlement.* However, it is unclear at the present time whether child sexual offenders with a mental disorder have similar or different cognitions which may have influenced their offending. This aim of the current study was to explore this.

Semi structured interviews eliciting cognitions were carried out with 12 adult male high secure child sexual offenders. Content analysis indicated that the majority of the cognitive distortions exhibited by this sample of men could be categorized within Ward and Keenan's (1999) five implicit theories. Evidence of a possible new implicit theory representing deviant sexual interest in children, *Children as Sexually Attractive,* was also found. Additionally, child sexual offenders whose offending appeared to be associated with intimacy deficits were not felt to be adequately captured under the *Dangerous World* implicit theory, and the theme of 'Lonely World' was felt to be more suitable to represent this group of men. Diagnosis did not impact upon the presence of implicit theories although content differences were found. Participants with a diagnosis of personality disorder (n = 5; 100%) more commonly articulated cognitions associated with the *Children as Sexual Beings* implicit theory and reported deviant sexual interest in children. In comparison, participants with a diagnosis of mental illness reported beliefs associated with the *Uncontrollability* implicit theory (n = 5; 100%), and only two men made reference to symptoms of their mental illness.

These preliminary findings appear to support previous studies identifying cognitions and personality as risk factors to sexual offending in men, irrespective of diagnosis. It can be concluded from this that psychosis alone is not a sufficient motivator for sexual offending and cognition appears to play an influential role. This is particularly relevant to those with a mental illness as the majority of research into their sexual offending up to now has mostly focused on the role of psychosis. In terms of assessment and treatment, these findings primarily suggest that implicit theories should be addressed in therapy rather than focusing solely on their surface level cognitive distortions, regardless of diagnosis. Further research is necessary in order to advance understanding of implicit theories in child sexual offenders with a mental disorder before any treatment and assessment tools can be adequately developed. Additionally, future research will build on the limited theories and typologies, particularly for those with a mental illness, which in turn should help to advance the assessment, formulation and treatment of these offenders.

Statement of Contribution

This statement of contribution is to certify that the information reported in this thesis comprises the author's original work, except where reference has been made to acknowledge the work of other researchers and research studies.

The author was solely responsible for identifying the research study and devising the study design, as well as for the writing of the thesis. The researcher was facilitated in the identification and recruitment of participants by a resident psychologist working in the secure hospital where the study took place. All interviews were individually carried out by the author, and both the author and an administrative secretary working in the secure hospital transcribed the interviews. Interview transcripts were individually analysed and coded by the author. Reliability checks were carried out by both the author's research and clinical supervisors.

The thesis is 34804 words in length, exclusive of tables, appendices and references of 'see extended paper'.

The research reported in this thesis was conducted in accordance with the principles for ethical treatment of human subjects as approved for this research by the following bodies: The University of Lincoln, The National Health Service Research Ethics Committee (NRES) and the Trust's participating Research and Development Committee.

RESEARCH ARTICLE

(As written for publication in Psychology, Crime & Law; See Guidelines Attached)

Implicit theories in high secure male child sexual offenders with a mental disorder

Karyn Mannix[a*], David L. Dawson[b] and Kerry Beckley[c]

[a]*University of Lincoln, UK;* [b]*University of Lincoln, UK;* [c]*Lincolnshire Partnership Trust, UK.*

Word Count:	6440
Word Count excluding 'references to extended paper' (290 words) and table (154):	5996

* Corresponding author. Email: karyn.mannix@nottshc.nhs.uk

Abstract

Content analysis of interviews with 12 high secure male child sexual offenders with a mental disorder indicated that the majority of their cognitive distortions could be categorized within five implicit theories previously identified in non-mentally disordered child sexual offenders. These include *Children as Sexual Beings, Nature of Harm, Uncontrollability, Dangerous World* and *Entitlement*. Evidence suggestive of an additional implicit theory, *Children as Sexually Attractive,* was also found. Diagnosis was found to impact upon the content rather than the presence of implicit theories within the current sample. All child sexual offenders with a diagnosis of personality disorder articulated cognitive distortions associated with the *Children as Sexual Beings* implicit theory and report a deviant sexual arousal to children typical of the classic preferential offender. In contrast, participants with a diagnosis of mental illness reported cognitions associated with the *Uncontrollability* implicit theory, although few reported psychotic symptoms as influencing their offending. Clinical implications of these results and suggestions for future research are discussed.

Keywords: child sexual offenders; mental disorder; implicit theories; cognitive distortions; high secure.

Introduction

Sexual violence against children is a serious social problem and the physical, emotional and psychological trauma suffered by victims makes the understanding of child sexual offenders imperative (Resick, 1993). Child sexual offending encompasses a diversity of behaviours, and child sexual offenders are a heterogenous group who commit a range of sexual offences for different reasons (Abel & Osborn, 1992). Various theories and multi-factorial models have been developed in an attempt to explain the aetiology and process involved in child sexual abuse, such as Finklehor's (1984) Precondition Theory, Hall and Hirschman's (1992) Quadripartite Model, Marshall and Barbaree's (1990) Integrated Theory, and Ward and Siegert's (2002) Pathways Model. Although these models offer various explanations for the aetiology and maintenance of sexual offending, factors such as deviant sexual arousal, distorted cognitions, affective dyscontrol and personality problems have been identified as playing a central role. Of particular interest to this study are distorted cognitions, explored from the perspective of Ward and Keenan's (1999) implicit theory hypothesis. Since the majority of sexual offenders against children are male (Langton & Marshall, 2001), this paper is concerned with male child sexual offenders only. [See Extended Introduction, p. 55]

Cognitive Distortions

Cognition is believed to be inexplicably intertwined with how a person interacts with and behaves within their social world (Gannon, 2009). Child sexual offenders are thought to experience their social world somewhat differently to non-offending men

and this social cognitive experience is believed to contribute to their sexual offending. Within the offending literature, many researchers have found that child sexual offenders hold beliefs which appear to facilitate and maintain their sexual offending behaviour, and often articulate statements which function to legitimise sexual relationships with children, and perceive adult-child sex as socially acceptable and benefiting children (Gannon, Ward & Polaschek, 2004; Ward, Hudson, Johnston & Marshall, 1997). The term 'cognitive distortions' has been used to refer to these maladaptive beliefs and attitudes (Abel, Becker & Cunningham-Rather, 1984). Examples of such cognitive distortions include statements such as 'children enjoy sexual contact with adults' or 'sex is good for children' (e.g. Abel et al., 1984; Ward, 2000). [See Extended Introduction, section 'Cognitive Distortions in Sexual Offending', p. 56]

According to Howitt (1995), cognitive distortions provide offenders with an interpretive framework that allows them to justify, rationalise, and excuse their maladaptive behaviours. Murphy (1990) proposed cognitive distortions are protective mechanisms which allow the offender to distance himself psychologically from his offending by (a) justifying it in terms of morality or psychological necessity, (b) minimizing the harm or consequences, and (c) attributing responsibility to victims. Cognitive distortions are therefore thought to assist the offender in continuing his abusive actions by overcoming personal inhibitions in relation to himself, society, and the victim (Finkelhor, 1984).

While no single theoretical model deals with the function and role of cognitive distortions in isolation, numerous studies recognise them as an important factor in child sexual offending (e.g. Abel et al., 1984; Kennedy and Grubin, 1992). A major criticism of this research concerns the ambiguity surrounding the definition and function of cognitive distortions. For example, some researchers argue that they serve as precursors to offending (e.g. Finkelhor, 1984), while others suggest they act as post-offence self-esteem maintenance strategies (e.g. Murphy, 1990). Researchers have also typically focused on the content of these distortions, discussing them as if they exist independently of one another (Drake, Ward, Nathan & Lee, 2001). This is incongruent with other psychological literature which has attempted to develop a theoretical account of the structures generating these cognitive distortions. Drawing on cognitive, developmental, and personality literature, Ward and his colleagues (Ward, 2000; Ward & Keenan, 1999) propose that an offender's cognitive distortions arise out of underlying schema called implicit theories, which in the context of other risk factors, increase the risk of sexual offending occurring. [See Extended Introduction, section 'Research examining cognitive distortions in child sexual offenders' & 'Critique', p. 58]

Implicit Theories and Child Sexual Offending

Implicit theories are defined as personal constructions about particular phenomena that reside in the minds of individuals (Sternberg, Conway, Ketron & Bernstein, 1981). Ward (2000) suggests that cognitive distortions are the product of these implicit theories, developed during the offender's adverse childhood as he tries to understand and make sense of unusual negative events (e.g. neglect, violence).

Implicit theories are therefore hypothesised to be maladaptive and to influence the offender to attend to, perceive, and interpret their social world in offence congruent ways (Ward, 2000). Implicit theories guide the offender's interpretation of the world so that information supportive of a theory is highlighted and inconsistent evidence is discarded or reinterpreted to fit that theory (Gopnik & Meltzoff, 1997). [See Extended Introduction, section 'Implicit theory approach to sexual offending', p. 63]

Examining relevant questionnaires and previous research, Ward and Keenan (1999) hypothesised that child sexual offenders articulate distorted cognitions indicative of five distinct implicit theories, which account for the majority of these distortions. These include:

Children as sexual beings

This refers to the belief that children have sexual wants and needs and have the capacity to make informed decisions regarding sex with adults. For example, '*the child seduced me'* (Ward & Keenan, 1999, p. 832).

Nature of Harm

This theory is based on two beliefs: (1) there are degrees of harm, and (b) some sexual acts are beneficial and unlikely to cause harm. A cognitive distortion generated by this implicit theory includes, '*it was only a bit of fun anyway'* (Ward & Keenan, 1999, p. 832).

Uncontrollability

This implicit theory is based on the belief that the offender's behaviours and actions are outside of his control and attributed to external factors. For example, '*alcohol made me do it'* (Ward & Keenan, 1999, p. 831).

Dangerous World

There are two streams of thought involved in this implicit theory. The first variant is conceptually related to a perception of the world as a hostile place where it is necessary to achieve dominance over others. The second variant also focuses on the dangerousness of the world and others; however children are thought to be reliable and trustworthy. A supportive cognition would include '*children are much safer than adults*' (Ward & Keenan, 1999, p. 832).

Entitlement

This theory is based on the belief that offenders' sexual and non-sexual needs are paramount to others and they are entitled to have their needs met when they want by whoever they chose. For example, '*I created her she is mine"*'(Ward & Keenan, 1999, p. 839).

[See Extended Introduction, section 'Child Sexual Offenders' Implicit Theories', p. 66]

Ward and Keenan (1999) propose that these five implicit theories account for the majority of cognitive distortions in the literature they reviewed. Since Ward and

Keenan's (1999) work, some other studies have found further evidence for these theories (e.g. Marziano, Ward, Beech & Pattison, 2006; Saradjian & Nobus, 2003), while others have not (e.g. Gannon, Wright, Beech & Williams, 2006). All of this research has involved incarcerated child sexual offenders or community based samples, none of whom were identified as having a mental disorder (i.e. a mental illness and/or personality disorder). Consequently, whether evidence of Ward and Keenan's (1999) five child sexual offender implicit theories, or evidence of new theories, is found in mentally disordered sexual offenders remains to be explored [See Extended Introduction section 'Critique', p. 70]

Child Sexual Offenders with a Mental Disorder

In contrast to the abundance of literature on the aetiology and maintenance of child sexual offenders in general, research concerning child sexual offenders with mental disorders is limited. In particular, Drake and Pathe (2004) found there is a 'paucity of research on the mentally ill who engage in deviant sexual practices, particularly child molestation' (p. 115). This may be due to the relatively low rate of sexual offences amongst this group (Alish et al., 2007), and the belief that their sexual offending is directly related to their psychotic symptoms (e.g. Jones, Huckele & Tanaghow, 1992). However, other studies have challenged this belief, proposing that psychotic symptoms alone are insufficient to explain sexual offending and other factors, including cognitions and personality, are involved (e.g. Greenall & Jellico-Jones, 2007). [See Extended Introduction section 'Literature on Sexual Offenders with a Mental Disorder', p. 71]

Drake and Pathe (2004) developed a typology to make sense of these inconsistencies, proposing that mentally ill sexual offenders fall into four groups: (1) those with pre-existing deviant sexual activities/interests; (2) those whose deviant sexuality arises in the context of mental illness and/or its treatment; (3) those whose deviant sexuality is a manifestation of more generalised antisocial behaviour; and (4) factors other than the above (e.g. acquired brain damage). [See Extended Introduction, section 'Child Sexual Offenders with a Mental Illness', p. 72]

Many of the factors linked with sexual offenders are consistent with the hallmark symptoms of personality disorders. Over the past 20 years, researchers studying personality disordered sex offenders have reviewed differences among sub-groups with regard to the type of sexual offence and victim (Murray, Briggs & Davies, 1994), degree of psychopathology of the offender (e.g. Ahlemer, Kleinsasser, Stoner & Retzlaff, 2003) and personality characteristics (Bogaerts, Vanheule & Desmet, 2006). The schizoid personality disorder, for example, has been found to be a very strong predictor of child molestation (e.g. Seto & Barbaree, 1999). Bogaerts et al. (2006) relate the description of the schizoid individual to Finkelhor's (1984) theory of emotional congruence and blockage, in that these individuals are frequently blocked from engaging in adult relationships by previous negative experiences or limited relational interests, and often feel more comfortable in relating to children. Emotional congruence with children appears to have conceptual links with Ward and Keenan's (1999) *Dangerous World* implicit theory. However, as seen in relation to those with a mental illness, the role of cognition in child sexual offenders with a personality disorder has been largely neglected within

the literature. Given that implicit theories are proposed as important treatment targets (e.g. Mann & Beech, 2003), the implicit theories of these offenders require attention. [See Extended Introduction section 'Child Sexual Offenders with a Personality Disorder', p. 76]

Study Aims and Hypotheses

Implicit theories are hypothesised to play an important role in child sexual offending, but there is a lack of knowledge concerning their presence and role in mentally disordered child sexual offenders. As this study was an exploratory investigation, no explicit hypotheses were made, although two questions guided the research:

1) Will evidence of Ward and Keenan's (1999) five hypothesised child sexual offenders' implicit theories, or new implicit theories, be found in a group of high secure child sexual offenders with a mental disorder?

2) Will diagnosis impact upon the type of implicit theories found in these offenders?

[See section 'Rationale for Study' & 'Extended Aims and Hypotheses', p. 79]

Method

Design

This study used a qualitative exploratory design to identify whether there was any evidence for Ward and Keenan's (1999) five hypothesised child sexual offenders'

implicit theories, or new theories, within the targeted sample. Participants completed a semi structured interview, which was analysed using content analysis (Weber, 1990). Content analysis was chosen based on (1) its strength in determining the presence of preconceived themes and new data (Willig, 2001), and (2) its documented use in other studies investigating implicit theories in sexual offenders (e.g. Marziano et al., 2006). [See Extended Method, section 'Design', p. 81]

Participants

Twelve adult male child sexual offenders with a mental disorder recruited from a high secure hospital in the UK participated in this study. Using a purposive sampling technique to identify participants, participants were selected for inclusion if they had (1) a clinical diagnosis of mental Illness (e.g. schizophrenia) and/or personality disorder; and (2) a documented history of a contact sexual offence against a child. Within the current study, a child was considered to be anyone below the age of 16 years.

Participants were excluded from the study if (1) their Responsible Clinician (RC) felt they could not provide informed consent; (2) the participant refused consent to be interviewed/recorded; (3) the participant was floridly psychotic impacting on their ability to give consent and/or to be interviewed; (4) the participant had committed sexual offences against adult victims only; (5) the participant had a diagnosis of learning disability; or (6) the participant could not speak English fluently.

Participants were classified into three groups on the basis of clinical diagnosis: mental illness (MI; n = 5); personality disorder (PD; n = 5); and dual diagnosis (MIPD; n = 2). The ages of the sample ranged from 33 to 61 years (mean = 45.3yrs; SD = 9.69yrs). Participants were classified as intrafamilial offenders if all of their known offending was against a member of their own family, or involved children within a current/previous relationship (n = 3). Participants were categorised as extrafamilial offenders if they had offended against children with whom they had no biological or legal relationship (n=8). Participants who offended against children both within and outside their family were classified as extrafamilial (n = 1). The age range of victims was from 18 months to 15 years, and included male and female victims. All participants had completed a cognitive behavioural sexual offender treatment program (SOTP) (n = 7), or were undergoing SOTP treatment (n = 5) at the time of the study. [See Extended Method, 'Participants' section, p. 90]

Measures

A semi structured interview schedule, devised by Ward, Louden, Hudson and Marshall (1995), was used to explore participants' implicit theories. To help facilitate an open and honest discussion of each participant's offending, each interview commenced with a framing statement, asking the participant to think back to and describe his life at the time of his offence from the perspective of the person he was at that time. The interview was divided into three sections with broad, open questions focusing on participants' cognitions and feelings towards themselves and their victim before, during, and after their sexual offences. [See Extended Method, 'Measures' section, p. 93]

Ethical Approval and Consent

The study was conducted according to the Code of Ethics of the British Psychological Society. Ethical approval was granted by the National Health Service Research Ethics Committee (NRES), the participating Trust's Research and Development Committee (R&D), and the University of Lincoln's Ethics committee. [See Extended Method, 'Ethical Approval and Consent' section, p. 96]

Procedure

Following ethical approval, a resident psychologist working in the hospital identified participants from the patient database system using the study inclusion and exclusion criteria. Study information sheets and consent forms were then sent to the appropriate RCs requesting permission for patients under their care who met the inclusion criteria to be invited to participate. After consulting participants, those who gave consent were provided with study information and consent forms. They were given one week to review this information and return the consent forms to the researcher if they chose to participate.

Participants who agreed to take part were interviewed individually by the researcher in a private room on their ward. Interview duration ranged from between 50–70 minutes in duration. Issues of confidentiality were reiterated prior to commencing and interviews were tape-recorded for later transcription and coded for anonymity. Participants' clinical diagnosis was also marked on transcripts. [See Extended Method, 'Procedure' section, p. 95]

Data Analysis

Transcribed interviews were divided into the three diagnostic groups - mental illness (MI), personality disorder (PD), dual diagnosis (MIPD) - and analysed separately using content analysis (Weber, 1990). The main author (KM) referred to Ward and Keenan's (1999) descriptions of their five implicit theories to collate cognitions suggestive of each one. This was used as the coding template. Working independently with clean copies of the transcripts, the three authors used this template to decide whether there was evidence of these themes in participants' offence descriptions. Where statements supportive of an implicit theory were found, they were labeled with the initials of the appropriate implicit theory. There was also a 'miscellaneous' category. This meant that statements/phrases which did not appear to fit Ward and Keenan's (1999) predetermined categories, but which appeared to be functionally related to the participant's offence, could be examined to see if they provided conceptual material for new implicit theories. When completed, raters re-examined transcripts and recorded participants' implicit theories and supportive statements in their individual coding sheets. Raters then met up to carry out reliability checks on their identification of implicit theories and allocation of statements to the implicit theory and miscellaneous categories [See Extended Method, 'Plan of Analysis' and 'Evaluation of Research' sections, p. 99-105]. The type and frequency of participants' implicit theories was recorded (Table 1).

Results

The results of the two main questions guiding this exploratory investigation will be reported separately.

Question 1

Evidence for all of Ward and Keenan's (1999) five implicit theories was found in this sample of high secure child sexual offenders with a mental disorder. Raters' individual coding sheets indicated they had identified the same implicit theories for each participant (100% agreement). Regarding the reliability of their allocation of statements to the implicit theory and miscellaneous categories, following discussion, raters agreed on 100% of the statements classified into the implicit theories categories except for two statements related to the Dangerous World implicit theory. The decision of how to classify these two statements was made by raters reaching a consensus in post-coding deliberations [See Extended Results, p. 105]. Table 1 shows the distribution of each implicit theory classification across the offence descriptions for each participant. An 'X' denotes the presence of an implicit theory (IT). The number in brackets illustrates the frequency of statements supportive of that implicit theory.

Children as Sexual Beings

Six participants (50%) articulated cognitive distortions associated with this theory. These men reported that they saw the child in their offence as having wanted and encouraged the sexual abuse, as well as being capable of deciding for themselves

Table 1. Distribution of implicit theories (ITs) in participants' transcripts.

Participant Group	Children as Sexual Beings	Nature of Harm	Uncontrollability	Dangerous World	Entitlement	Miscellaneous
MI						
1		X (7)	X (17)		X (6)	
2			X (14)		X (4)	X (6)
3	X (12)	X (5)	X (7)	X (4)	X (3)	
4			X (6)	X (13)	X (7)	
5		X (1)	X (7)	X (4)	X (3)	
MI/PD						
6			X (7)	X (20)	X (9)	
7			X (21)	X (9)	X (8)	
PD						
8	X (15)	X (15)		X (6)	X (3)	X (3)
9	X (4)	X (8)		X (10)	X (3)	X (8)
10	X (15)	X (8)	X (12)		X (9)	X (5)
11	X (11)	X (9)	X (4)	X (3)	X (4)	X (5)
12	X (9)	X (6)	X (4)	X (7)	X (4)	X (6)
Total ITs Across groups	6	8	10	9	12	6

to engage in the sexual activity. Confirmatory evidence of this was found by the men attributing their own sexual preoccupations to the children around them. Innocent everyday child behaviours were interpreted as indicating sexual intent. Some men reported that they perceived the relationship with their victim as adult-to-adult rather than adult-to-child, attributing responsibility for the abuse to the child. They often redefined the abuse in terms of love and reciprocation, believing themselves to be in a mutually satisfying love affair.

Examples from transcripts:

"I would *see her with her pants off and so I knew what she wanted"*

'She teased me……..most of the time it was her who started it'

[See Extended Results, 'Children as Sexual Beings' section, p. 107].

Nature of Harm

Evidence for this theory was found in eight men (66.6%), and arose out of their belief that there is nothing inherently damaging about having sex with children who have sexual needs and desires. These men suggested that the child in their offence was not harmed because they did not use force or threats, or have sexual intercourse. The child's response was interpreted by them as either tacit or explicit permission to continue. When a child expressed pain or discomfort, it was perceived in a sexual way or ignored. A child's silence was also interpreted as an invitation for sexual abuse.

Examples from transcripts:

'I just stroked her leg and she didn't say nothing really from the start. She enjoyed it'

[See Extended Results, 'Nature of Harm' section, p. 110]

Uncontrollability

Evidence supporting this implicit theory was found in ten of the men (71.66%). They commonly described having uncontrollable sexual needs which they felt driven to fulfil. Other reasons included their own childhood abuse, anger, and paranoia. They often referred to themselves as being '*weak'* because they could not refrain from acting on these various influences.

Example from a transcript:

'It was sort of like sex was on my brain all the time, I couldn't control it'

Only two of the seven men with a diagnosis of mental illness alluded to this implicit theory in their sexual offending. They felt their persecutory thoughts potentiated their pre-existing paranoia and suspiciousness and played an indirect role in their offending. [See Extended Results, 'Uncontrollability' section, p. 112]

Dangerous World

Evidence for this theme was found in nine of the men (75%). Only two participants held the first variant of this theory, which appeared to guide their information

processing towards perceiving threats from both adults and children where evidence was absent or ambiguous. They felt their abusive behaviour towards others was a justified preemptive action to prevent harm to their self. They reported anger and revenge as driving forces in their offending.

All other seven participants held the second variant, reporting children to be their only source of safety and comfort in an otherwise rejecting world. They met their needs for emotional and physical intimacy through sexual contact with children. Children's emotional responsiveness and innocence appeared to contrast with the rejection they knew of adults, giving participants a sense of belonging and of being cared for. These men described being blocked from achieving this level of comfort and intimacy with adults, consequent to their previous abusive experiences.

Examples from a transcript:

'*I could relate to adults on a talk basis, sexually I couldn't. I felt because of what happened to me, they're all going to be like that. A child would never leave'*

'*I just wanted to belong to something*'

[See Extended Results, 'Dangerous World' section, p. 115]

Entitlement

All participants (100%) within the sample provided evidence of a sense of entitlement to offend. Participants described their sexual offending as gratifying

their own needs, sexual and non-sexual, which were seen as paramount. One man explained:

'*If I'm honest I didn't really care about anybody else as long as I got what I wanted"*

These men, specifically those who were known to the child, believed they were entitled to have sex with the child, regardless of the child's needs, preferences, or desires. One man saw it as his patriarchal right.

'I needed sex more than what my wife wanted and we had three young children"

This implicit theory is self-serving and appeared to legitimise participants' perceived importance and right to dominate others, while providing justification for ignoring the child's needs, wants and desires. [See Extended Results, 'Entitlement' section, p. 118]

Miscellaneous

Half of the transcripts analysed contained statements which raters collectively agreed did not appear to fit the original descriptions of any of Ward and Keenan's (1999) five pre-existing implicit theories. Having explored this data further, there were some statements which raters did not feel were indicative of any separate categories not already captured by Ward and Keenan's (1999) existing implicit theories. Examples included:

'*the risk of being caught was exciting'*

'I was hoping people would just forget about me'

However, there were other statements which raters felt were collectively indicative of deviant sexual interests in children. These included:

'I fancy her, I wouldn't mind touching her'

'She was beautiful, big beautiful round eyes'

'The complexion, it just attracts me all the time'.

Although Beech, Parrett, Ward and Fisher (2009) included statements illustrating deviant sexual interests in children under the *Children as Sexual Beings* implicit theory in their study on female sex offenders, Ward and Keenan (1999) make no reference to this factor in their original description of their theory. Thus, there appears to be a lack of clarity regarding the definition of *Children as Sexual Beings* and a need for this theme to be re-examined to ascertain whether this implicit theory can be used to encapsulate statements illustrating paedophilic interests, or whether they are deserving of an additional implicit theory, '*Children as Sexually Attractive'.* [See Extended Results, 'Miscellaneous' section, p. 119]

Question 2

Table 1 illustrates the distribution of implicit theories across the three diagnostic groups. As can be seen, there appears to be different clusters of implicit theories forming in each of these groups. For example, in the first diagnostic group, mental illness, 'Uncontrollability' and 'Entitlement' implicit theories are predominately indicated, whereas 'Children as Sexual Beings' implicit theory is rare. This is in comparison to the third diagnostic group, personality disorder, where sexualized

beliefs and arousal to children was the norm. For example, the 'Children as Sexual Beings' implicit theory was found to be suggested in the transcripts of all these men (n = 5; 100%), as was a deviant sexual arousal to children as illustrated by the miscellaneous category (n = 5; 100%). The low number of men within each of the diagnostic subgroups hinders the generalisability of the findings, but does suggest this may be an interesting area to explore further. [See Extended Results, p. 121]

Discussion

In response to the two study questions, evidence was found for all of Ward and Keenan's (1999) child sexual offenders' implicit theories - Children as Sexual Beings (50%), Nature of Harm (66.6%), Uncontrollability (71.66%), Dangerous World (75%), and Entitlement (100%) – as well as statements which appeared to be functionally related to participants' offending but which could not be categorised within Ward and Keenan's (1999) original descriptions. There was also an indication of content differences in the implicit theories between the three diagnostic subgroups. These findings are now discussed. [See Extended Discussion, p. 123]

In this study, child sexual offenders with a mental disorder reported cognitive distortions associated with the five implicit theories found in non-mentally disordered child sexual offenders. This suggests the universality of the attitudes, beliefs and goals embedded in these five implicit theories in these child sexual offenders, irrespective of diagnosis. [See Extended Discussion, p. 124-127]. However, some differences were noted. For example, raters did not feel that

participants' statements illustrating their paedophilic interests in children were entirely consistent with the descriptions of Ward and Keenan's (1999) theories. Although other researchers (Beech et al., 2009) have classified such statements under the *Children as Sexual Beings* implicit theory, Ward and Keenan's (1999) description of this theory does not encapsulate deviant sexual arousal and is more focused on the offender's interpretations of the child's behaviours and actions, as opposed to the offender's sexual interest and attraction to children in general. Men who perceive children as being sexually aware, however, are not necessarily sexual attracted to and aroused by children. This was illustrated in this study by a participant in the mental illness group who reported paedophilic interests in children but who did not perceive children as sexual beings.

Paedophilic interests in children has long been recognised as an important precipitating and maintaining factor in aetiological models of child sexual offending (e.g. Finkelhor, 1984), as well as being predictive of sexual recidivism (Hanson & Morton-Bourgon, 2005). Because child sexual offenders often disclose deviant sexual arousal to children, accurately identifying and targeting this in treatment is important in efforts to reduce the risk of re-offending. Consequently, it is hypothesised that the theme of deviant sexual arousal found in this study provides support for the presence of an additional implicit theory, *Children as Sexually Attractive,* or the need for an interesting extension to the existing *Children as Sexual Beings* implicit theory. If further research supports these theories as being distinct, children being perceived as sexually desirable should be separated out

from children being seen as sexual agents. [See Extended Discussion, 'Miscellaneous' section, p. 127]

Raters also noted the significant diversity between the men fitting the two variants of Ward and Keenan's (1999) *Dangerous World* implicit theory in terms of their emotional tone, cognitions and motivating drives for their sexual offending. The emotional tone of these offenders was also thought to reflect the different treatment needs of these groups. Only two men held the first variant of this theory and reported the world and others as hostile and dangerous. Their emotional tone was characterized by anger. It was more common for participants to hold the second variant of this theory and report an emotional congruence to children, a level of intimacy that they did not feel they could achieve with adults consequent to earlier difficult attachments and experiences. The importance of emotional congruence in child sexual offending has been supported by previous findings (e.g. Finkelhor, 1984; Hartley, 2001; Mann & Hollin, 2001) and Ward and Keenan's (1999) *Dangerous World* implicit theory was felt to be less suited to adequately capturing cognitions indicative of this. The term 'Lonely World' was felt better to reflect the importance of this theme. It is hypothesised that such a theme can exist independently to that of *Dangerous World*, given that offenders who view the world as lonely may not necessarily hold the hostile view that the world is dangerous. Additionally, this finding is consistent with previous studies finding hostile cognitions to be more typical of rapists than child sexual offenders, for whom intimacy deficits and sexual preoccupation are most salient (Mann & Hollin, 2001). Further research

could clarify whether this theme merits greater representation and signifies a separate implicit theory. [See Extended Discussion, 'Lonely World' section, p. 129]

The second research question concerned diagnostic differences with regard to implicit theories. Although a diagnosis of mental illness and/or personality disorder did not affect the presence of implicit theories in this sample of men, the findings did indicate a difference in the content of implicit theories across the diagnostic subgroups. Because of the small number of participants in each of these diagnostic subgroups, findings are not conclusive but they highlight some interesting patterns which would benefit from further research. For example, the most prevalent theme for participants with a mental illness was *Uncontrollability* (n=7; 100%) while sexualized beliefs about children were rare. There are several possible interpretations of this finding given that the construct of Uncontrollability is very broad and does not specify, for example, whether an offender's reported uncontrollability was specific to that victim or situation, or representative of a more global personality trait. One hypothesis is that this finding supports previous research suggesting mental illness acts as a disinhibitor (e.g. Crassati & Hodes, 1992). By definition, disinhibition assumes the prior existence of factors relating to the propensity for sexual offending. The fact that these men also reported distorted cognitions appears to fit with this idea that symptoms of mental illness enable inhibition in conjunction with other potentiating factors. This finding may also be supportive of broader research identifying impulsivity or self-regulation difficulties in child sexual offenders (Marshall & Barbaree, 1990). Alternatively, participants'

uncontrollability statements may act as *post hoc* justifications for their sexual offending.

Interestingly, participants reported 'uncontrollable' sexual urges as the main causal factor in their offending and only two men made reference to their psychotic symptoms. Both stated their persecutory thoughts reinforced their long-standing paranoia and general suspiciousness of others (linked to the *Dangerous World* implicit theory). They reported no sexual gratification from their offence, which were another example of antisocial behaviour in their lengthy and diverse criminal histories. These men appear to fit group three of Drake and Pathe's (2004) typology, which suggests that their sexual offending is a result of more generalized anti-social behaviour. Consequently, it could be hypothesised that their sexual offending related to pre-morbid, longstanding developmental vulnerabilities, personality features and deficits in cognition, rather than the direct effects of their mental illness. This finding, although preliminary, appears to be consistent with previous studies suggesting factors other than mental illness (e.g. personality and cognition) are important when understanding the actions of mentally ill sex offenders (Smith, 2000) and when assessing future risk.

In contrast, participants with a diagnosis of personality disorder reported beliefs more typical of the fixated paedophilia offender (Groth, 1979). They all reported cognitions associated with the *Children as Sexual Beings* implicit theory (n=5; 100%) and reported a deviant sexual arousal to children (n=5, 100%). These men reported attributing sexual intent to the child's behaviour and interpreting the

child's responses as permission to continue. This does not imply that the child colluded in the abuse but illustrates Ward's (2000) stance on how offenders perceive and interpret their victim's desires, wants and needs to fit their underlying implicit theory. Thus, men who perceive children as sexually aware beings are more at risk to sexually abuse children than men who perceive children as innocent. These results highlight the heterogeneity of child sexual offenders' implicit theories and the importance of being aware of an offender' theories in developing individual formulations and treatment needs and risks [See Extended Discussion, p. 133 and Clinical Implications, p. 134]

This is the first study to examine Ward and Keenan's (1999) child sexual offenders' implicit theories in child sexual offenders with a mental disorder. The presence of cognitive distortions indicative of these implicit theories was the norm in this sample and has important implications in terms of assessment and treatment. Primarily, it provides evidence of the importance of addressing these underlying beliefs in all child sexual offenders, irrespective of diagnosis. As was demonstrated in this study, patterns of dysfunctional thinking persisted in participants who had completed a cognitive behavioural SOTP involving careful challenging of their offence related cognitive distortions. This questions the usefulness in directing sole attention to addressing these surface level cognitions, or of addressing them in general. Mann and Beech (2003) argue it is important to address the underlying implicit theories thought to generate cognitive distortions in order to achieve long term change and suggest the use of schema therapy (Young, 1990), which targets these structures. Although only preliminary evidence exists for

this approach (Thornton & Shingler, 2001), results suggest that incorporating schema work into offence focused interventions lead to reductions in cognitive distortions and underlying structures in comparison to offence focused interventions only. Although schema interventions were originally developed for individuals with personality disorders (Young, 1990), this study suggests their suitability to individuals with mental illness, rather than interventions predominantly focused on managing their psychotic symptoms. Young (1990) delineated 16 maladaptive schemas and it would be interesting for future studies to examine their relationship with Ward and Keenan's (1999) implicit theories. Assessing for the presence of these schemas in child sexual offenders would be a useful indicator in terms of the clinical relevance of schema focused interventions. [See Extended Discussion, 'Clinical Implications' section, p. 134]

Knowing that child sexual offenders report these cognitions does not, however, inform our knowledge about their origins or function in the offender's sexual offending, or how best to conceptualise and work with them in treatment. It is difficult to know with certainty whether these cognitions are actually the product of implicit theories that bias information processing, or whether they can be seen as operating as excuses or justifications for offending. Child sexual offenders are a heterogeneous group and there are multiple reasons why they may disclose distorted cognitions. While some intentionally distort their offence details because of fears of negative consequences (e.g. Hanson & Mourton-Bourgon, 2005) or to maintain self-esteem, others engage in denial and distortion as self-protective mechanisms (Proeve & Howells, 2006), and others may believe their actions did

not constitute sexual offending as a result of their implicit beliefs and common cognitive processes (e.g. Ward, 2000). Consequently, it is not known whether they are precursors to offending or whether they act as post-offence self-esteem maintenance strategies. If they are present pre-offence this would suggest that they important treatment targets as opposed to operating post offence and representing the normative justifications or excuses used by everyone to reduce cognitive dissonance (Mann & Shingler, 2006; Maruna, 2001).

Admission of offence details has not consistently been found to be essential to treatment progress and success (Hanson & Mourton-Bourgon, 2005) and thus questions the long held assumption that all child sexual offenders' cognitions are unhealthy and need to be challenged. In a series of articles, Marshall and his colleagues (2002; 2003) found that therapist qualities including empathy, warmth, directiveness and reward were key in predicting treatment benefits in sexual offenders. These findings suggest that determining the function of an offender's cognitive distortions using a collaborative rather than a confrontational style is important in delivering effective treatment (e.g. Marshall, Anderson, & Fernandez, 1999; Maruna & Mann, 2006). Ward and Keenan's (1999) implicit theory hypothesis provides only an organising framework for these distorted cognitions and should be used in conjunction with a model of sexual offending, for example Finkelhor's (1984) Precondition Theory, to help explore the function of offenders' cognitions at different stages of their offence process. Furthermore, as Gannon, Ward and Collie (2007) recommend, incorporating implicit measures of cognitions into treatment

programs as opposed to reliance on self-reports measures, would help to curtail social desirability. [See Extended Discussion, 'Clinical Implications' section, p. 134]

Limitations

As child sexual offenders with a mental disorder are a small and distinct group, large-scale quantitative methodologies are not always possible. The methodology employed in this study has limitations, however, and this warrants cautious interpretation of the results. First, the design of this study relied solely on retrospective self report, and child sexual offenders have been shown to be prone to responding in socially desirable ways (Hayashino, Wurtele & Klebe, 1995). Second, although the sample size consisted of a large proportion of the known population of interest and thus can be seen to be a good representation of high secure child sexual offenders with a mental disorder, the size does potentially limit attempts to examine diagnostic differences with regard to implicit theories. Third, participants were drawn from a single maximum security hospital, limiting representativeness of other settings. An additional shortcoming of the sample composition concerned participants' different levels of treatment exposure. Participants in this study had either completed treatment or were engaging in treatment, and could have more insight into their thought processes then they may have had before treatment, affecting the content and number of cognitive distortions exhibited (e.g. Gannon & Polaschek, 2006). However, difficulties in recruiting untreated offenders have been noted (Marshall & Barbaree, 1998). Further research within this area should use a larger sample of child sexual offenders recruited from lower security and community settings. Level of treatment

exposure should also be controlled for in order to expand the generalisability of these findings. Additionally, triangulation of findings using different methods (e.g. implicit measures using response latencies and reaction times; Dawson, Barnes-Holmes, Gresswell, Hart, & Gore, 2009) would enhance validity. [See Extended Discussion, 'Methodological Limitations and Future Research' section, p. 138]

Conclusion

This exploratory study found support for Ward and Keenan's (1999) implicit theories hypothesis in a sample of male high secure child sexual offenders with a mental disorder, adding to the literature base on this under-researched group as well as to the empirical support for this approach. Evidence for possible new theories, or extensions to existing ones was also suggested. Replication and development of other studies building on these findings is necessary for further progression in this area. It is hoped that future research will enhance our understanding of implicit theories in this group of child sexual offenders and build on the limited theories and typologies, particularly for those with a mental illness, which in turn should help to advance the assessment, formulation and treatment of these offenders.

References

Abe, G.G., Becker, J.V., & Cunningham-Rathner, J. (1984). Complications, consent and cognitions in sex between children and adults. *International Journal of Law and Psychiatry, 7*(2)*,* 89-103.

Abel, G. G., & Osborn, C. (1992). The paraphilias: The extent and nature of sexually deviant and criminal behaviour. *Psychiatric Clinics of North America*, *15*(3), 675-701.

Ahlmeyer, S., Kleinsasser, D., Stoner, J., & Retzlaff, P. (2003). Psychopathology of incarcerated sex offenders. *Journal of Personality Disorders, 17(*4), 306-318.

Alish, Y., Birger, M., Manor, N., Kertzman, S., Zerzion, M., Kotler, M., & Strous, R.D. (2007). Schizophrenia sex offenders: A clinical and epidemiological comparison study. International *Journal of Law and Psychiatry, 30*(6), 459-466.

Beech, A. R., Parratt, N., Ward, T., & Fisher, D. (2009). Assessing female sexual offenders' motivations and cognitions: An exploratory study. *Psychology, Crime, & Law, 15*(2), 201-216.

Bogaerts, S., Vanheule, S., & Desmet, M. (2006). Personality disorders and romantic adult attachment: A comparison of secure and insecure attached child molesters. *International Journal of Offender Therapy and Comparative Criminology, 50*(2), 139-147.

Craissati, J., & Hodes, P. (1992). Mentally ill sex offenders: The experience of a regional secure unit. *British Journal of Psychiatry, 161*(1), 846-849.

Dawson, D.L., Barnes-Holmes, D., Gresswell, D. M., Hart, A.J., & Gore, N.J. (2009). Assessing the Implicit Beliefs of Sexual Offenders Using the Implicit Relational Assessment Procedure. *Sexual Abuse: A Journal of Research and Treatment, 21*(1), 57-75

Drake, C.R., & Pathe, M. (2004). Understanding sexual offending in schizophrenia. *Criminal Behaviour and Mental Health, 14*(1), 108-120.

Drake, C.R., Ward, T., Nathan, P., & Lee, J. (2001). Challenging cognitive distortions: An implicit theory approach. *Journal of Sexual Aggression, 7*, 25-40.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.

Gannon, T.A. (2009). Social cognition inn violent and sexual offenders: An overview. *Psychology, Crime & Law, 15*(2), 97-118.

Gannon, T. A., & Polaschek, D.L.L. (2006). Cognitive distortions in child molesters: A re-examination of key theories and research. *Clinical Psychology Review, 26*, 1000-1019.

Gannon, T.A., Ward, T., & Collie, R. (2007). Cognitive distortions in child molesters: Theoretical and research developments over the past two decades. *Aggression*

and Violent Behaviour, 12(4), 402-416.

Gannon, T.A, Ward, T., & Polaschek, D.L.L. (2004). *Child sexual offenders. Violence in society: New Zealand perspectives*. Christchurch: Te Awata Press.

Gannon, T.A., Wright, D.B., Beech, A.R., & Williams, S.E. (2006). Do child molesters hold distorted beliefs? What does their memory recall tell us? *Journal of Sexual Aggression, 12*, 5-18.

Gopnik, A., & Meltzoff, A.N. (1997). *Words, thoughts and theories*. Cambridge, MA: MIT Press.

Greenall, P.V., & Jellico-Jones, L. (2007). Themes and risk of sexual violence among the mentally ill: Implications for understanding and treatment. *Sexual and Relationship Therapy, 22*(3), 323-337.

Groth, A. N. (1979). *Men who rape: The psychology of the offender*. New York:

Plenum Press.

Hall, G.C.N., & Hirschman, R. (1992). Sexual aggression against children: A conceptual perspective of etiology. *Criminal Justice and Behaviour, 19*(1), 8-23.

Hanson, R.K., & Morton-Bourton, K.E. (2005). The characteristics of persistent offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

Hartley, C.C. (2001). Incest offenders' perceptions of their motives to sexually offend within their past and current life context. *Journal of Interpersonal Violence, 16*, 459-475.

Hayashino, D.S., Wurtele, S.K., & Klebe, K.J. (1995). Child molesters: An examination of cognitive factors. *Journal of Interpersonal Violence, 10*(1), 106-116.

Howitt, D. (1995). *Paedophiles and sexual offences against children.* New York:

John Wiley.

Jones, G., Huckele, P., & Tanaghow, A. (1992). Command hallucinations, schizophrenia and sexual assault. *Irish Journal of Psychological Medicine, 9*(1), 47-49.

Kennedy, H. G., & Grubin, D. H. (1992). Patterns of denial in sex offenders. *Psychological Medicine*, *22*(2), 191-196.

Langton, C.M., & Marshall, W.L. (2001). Cognition in rapists: Theoretical patterns by typological breakdown. *Aggression and Violent Behaviour, 6*(5), 499-518.

Mann, R.E., & Beech, A.R. (2003). Cognitive distortions, schemas and implicit theories. In T. Ward, D.R. Laws, & S.M. Hudson (Eds.), *Sexual Deviance: Issues and controversies* (pp. 135-153). Sage Publications: London.

Mann, R.E., & Hollin, C.R. (2001, November). *Schemas: A model for understanding cognition in sexual offending.* Paper presented at the Annual

Research & Treatment Conference, Association for the Treatment for Sexual Abusers, San Antonio.

Mann, R.E., & Shingler, J. (2006). Schema-driven cognitions in sexual offenders: Theory, assessment and treatment. In W.L. Marshall, Y.M. Fernandez, L.E. Marshall, & G.A. Serran (Eds.), *Sexual offender treatment: Contraversial issues* (pp.173-185). Hoboken, NJ: Wiley.

Marshall, W.L., Anderson, D., & Fernandez, Y.M. (1999). *Cognitive behavioural treatment of sexual offenders*. Chicester, UK: Wiley.

Marshall, W. L., & Barbaree, H. E. (1998). The long-term evaluation of a behavioural treatment program for child molesters. *Behavior Research and Therapy*, *6,* 499-511.

Marshall, W. L., & Barbaree, H. E. (1990). An integrated theory of the aetiology of sexual offending. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.),

Handbook of sexual assault: Issues, theories and treatment of the offender (pp. 257-275). New York: Plenum Press.

Marshall, W.L., Serran, G., Fernandez, Y.M., Mulloy, R., Mann, R.E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9,* 25-30.

Marshall, W.L., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y.M., Mann, R.E., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy, 9*, 395-405.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives.* Washington, DC: American Psychological Association.

Maruna, S., & Mann, R.E. (2006). A fundamental attribution error? Rethinking

cognitive distortions. *Legal and Criminological Psychology, 11*, 155-178.

Marziano, V., Ward, T., Beech, A.R., & Pattison, P. (2006). Identification of five fundamental implicit theories underlying cognitive distortions in child abusers: A preliminary study. *Psychology, Crime and the Law, 12*(1), 97-105.

Murphy, W. D. (1990). Assessment and modification of cognitive distortions in sex offenders. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 331-340). New York: Plenum Press.

Murray, K., Briggs, A., & Davies, A. (1994). Psychopathic disordered, mentally ill and mentally handicapped offenders: A comparison study. *Medicine, Science and The Law, 32*(2), 331-334.

Proeve, M., & Howells, K.H. (2006). Shame and guilt in child molesters. In W.L. Marshall, Y.M. Fernandez, L.E. Marshall, & G.A. Serran (Eds.), *Sexual*

offender treatment: Controversial issues (pp. 125-139). Chichester: John Wiley & Sons.

Resick, P.A. (1993). The psychological impact of rape. *Journal of Interpersonal Violence, 8(*2*),* 223-255.

Saradjian, A., & Nobus, D. (2003). Cognitive distortions of religious professionals who sexually abuse children. *Journal of Interpersonal Violence, 18,* 905−923.

Seto, M.C., & Barbaree, H.E. (1999). Psychopathy, treatment behaviour, and sex offender recidivism. *Journal of Interpersonal Violence, 14*, 1235-1248.

Smith, A. (2000). Motivation and psychosis in schizophrenic men who sexually assault women. *Journal of Forensic Psychiatry, 11*(1), 62-73.

Sternberg, R.L., Conway, B.E., Ketron, J.L., & Bernstein, M. (1981). People's conceptions of intelligence. *Journal of Personality and Social Psychology, 41*,

37-55.

Thornton, D., & Schingler, J. (2001). *The impact of schema level work on sexual offenders' cognitive distortions.* Paper presented at the 20th Annual Research and Treatment Conference for the Treatment of Sexual Abusers, San Antonio, USA.

Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories. *Aggression and Violent Behaviour, 5*(5), 491-507.

Ward, T., Hudson, S. M., Johnston, L., & Marshall, W. L. (1997). Cognitive distortions in sex offenders: An integrative review. *Clinical Psychology Review, 17*(5), 479-507.

Ward, T., & Keenan, T. (1999). Child molesters' implicit theories. *Journal of Interpersonal Violence, 14(*8), 821-838.

Ward, T., Louden, K., Hudson, S.M., & Marshall, W.L. (1995). A descriptive model of offence chain in child molesters. *Journal of Interpersonal Violence, 10*(1), 452-472.

Ward, T., & Siegert, R. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, & Law, 8*(1), 319-351.

Weber, R.P. (1990). *Basic content analysis*. Newbury Park, CA: Sage.

Willig, C. (2001*). Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, UK: Open University Press.

Young, J. E. (1990). *Cognitive therapy for personality disorders: A schema focused approach.* Sarasota, FL: Professional Resource Press.

Psychology Crime and Law Journal Guidelines for Authors

Format of Manuscripts

Manuscripts should be typed in double space with wide margins (3 cm).

Title page: This should contain the title of the paper (centered), the name and full postal address of each author and an indication of which author will be responsible for correspondence, reprints and proofs. Abbreviations in the title should be avoided.

Abstract: This should not exceed 200 words and should be presented on a separate page, indented both sides, centered, summarizing the significant coverage and findings.

Key words: Abstract should be accompanied by five key words or phrases that between them characterise the contents of the paper. These will be used for indexing and data retrieval purposes.

Paragraphs: Second paragraph of each section indented.

Displayed Quotations: indented left and right, smaller font, single inverted-comma.

Figures: All figures should be numbered with consecutive Arabic numerals, have descriptive captions and be mentioned in the text. Figures should be kept separate from the text but an approximate position for each should be indicated in the margin. Axes of graphs should be properly labeled and appropriate units given. Figures should be planned so that they reproduce to 10.5 cm column width. The preferred width of submitted drawings is 16 - 21 cm with capital lettering 4 mm high, for reduction by one-half.

Tables: Tables should be clearly typed with double spacing on a separate page. Number tables consecutively and give each a clear descriptive heading. E.g. Table 1. Title initial cap only (ranged left above table). Avoid the use of vertical rules in tables. Table footnotes should be typed below the table, designated by superior lower-case letters.

Lists: (1) for numbered lists. Bullets if wanted.

References: APA (American Psychological Association) references are used in the social sciences, education, engineering and business. For detailed information, please see the *Publication Manual of theAmerican Psychological Association*, 6th edn.

Appendix: Goes after references. Text smaller.

University Ethics Approval

----Original Message-----
From: Emile van der Zee [mailto:evanderzee@lincoln.ac.uk]
Sent: 23 March 2009 13:58
To: Mannix Karyn (LPT)
Subject: Thesis Ethics

Dear Karyn,

this is to confirm that received ethical approval for your project "Implicit Theories in a sample of High Secure Male Mentally Ill Sexual Offenders" on 23-3-09 from the School of Psychology's Ethics Committee.
All my best,

Emile

Emile van der Zee PhD
Principal Lecturer in Psychology
Programme director of the MSc in Child Studies
University of Lincoln
Lincoln LN6 7TS
evanderzee@lincoln.ac.uk

National Health Service Research Ethics Committee Ethics Approval Letter

NHS
National Research Ethics Service
Nottingham Research Ethics Committee 1
1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 01159123344 Ext: 39425
Facsimile: 01159123300

21 October 2008

Miss Karyn Mannix
Trainee Clinical Psychologist
Lincolnshire Partnership
University of Lincoln, Health, Life and Social Sciences
Court 11, Satellite building 8,
Brayford Pool, Lincoln
LN67TS

Dear Miss Mannix,

Full title of study: **Implicit Theories in High Secure Male Mentally Ill Child Sexual Offenders**
REC reference number: **08/H0403/126**

The Research Ethics Committee reviewed the above application at the meeting held on 14 October 2008. Thank you for attending to discuss the study.

Ethical opinion

In discussion, you clarified/confirmed the following ethical issues:

- You will be accessing participants' ward files to note details of their age, diagnosis, type of offence etc. It is important to know their type of offence as this data will be compared with the information they give of their offence (in their own words) during the interview.
- Participants might divulge information that may warrant breaking patient confidentiality. Therefore, you will be liable to pass on the new information that may be disclosed to you during the interviews i.e. any other offences. This information will be passed on to a member of staff.
- It is standard practice to gain consent from RMO.
- The PIS give provision to potential participants to contact you through the ward staff if they have any questions, before signing the consent form.
- There are 18 potential participants. It is expected that 8 of them will consent to taking part.
- A qualified psychologist working in the Mental Health Directorate has agreed to identify potential participants using the study's inclusion/exclusion criteria.
- There is the use of the word 'offence' throughout the interview schedule document. The Committee wished to know if participants perceive their deeds as an offence. You clarified that this word had been used in interviews in the past. However, this never presented a problem.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Application	AB/132820/1	05 September 2008
Participant Consent Form	1	01 September 2008
Participant Consent Form: Audio Recording	1	01 September 2008
Participant Consent Form: RMO	1	01 September 2008
Participant Information Sheet	1	01 September 2008
Participant Information Sheet: RMO	1	01 September 2008
Interview Schedules/Topic Guides	1	01 September 2008
Peer Review		03 September 2008
Protocol	1	01 September 2008
Investigator CV		05 September 2008
Peer Review		10 September 2008
Investigator CV		04 September 2008
Letter from Sponsor		02 September 2008
Compensation Arrangements		13 August 2008

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0403/126	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr K Pointon / Miss R Jibli
Chair / Co-ordinator

Email: rinat.jibli@nottspct.nhs.uk

Enclosures: *- List of names and professions of members who were present at the meeting and those who submitted written comments*

- "After ethical review – guidance for researchers"

Copy to:

Mr Mark Gresswell
University of Lincoln
Health Life and Social Sciences
Court 11, Satellite Building 8
Brayford Pool
Lincoln, LN6 7TS

R&D office for NHS care organisation at lead site - NHCT

Nottingham Research Ethics Committee 1

Attendance at Committee meeting on 14 October 2008

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Alastair Allen	Lay Member	No	
Dr Martin Anderson	Associate Professor in Mental Health	Yes	
Dr W P Bouman	Consultant Psychiatrist	No	
Professor Cris S Constantinescu	Consultant Neurologist	Yes	
Ms H Crow	Research Midwife	Yes	
Mr Robert Johnson	Research Co-ordinator	No	
Rev Keith Lackenby	Lay member	Yes	
Mr J Merrills	Barrister / Pharmacist	Yes	
Mr Robert Oldroyd	Lay member	Yes	
Dr N Philips	General Practitioner	Yes	
Miss Jayne Platts	Research Midwife	Yes	
Dr K Pointon	Consultant Radiologist	Yes	
Mr Ian Thompson	Lay member	Yes	
Professor David Upton	Professor of Pharmacy Practice and Research	Yes	
Mrs Shirley E White	Lay member	Yes	
Ms L Wojciechowicz	Senior Community Physiotherapist	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss Rinat Jibli	Committee Coordinator

Nottingham Research and Development Committee

Nottinghamshire Healthcare NHS
NHS Trust

E-mail: jayne.simpson@nottshc.nhs.uk

Research Management and Governance
B21, B Floor
Gateway Building
University of Nottingham
Innovation Park
Triumph Road
Nottingham NG7 2TU

Tel: 0115 8231295

Trust research study ref: FOR/03/02/09
(please quote in all correspondence)

3rd February 2009

Miss Karyn Mannix
Trainee Clinical Psychologist
Lincolnshire Partnership
University of Lincoln, Health, Life and Social Sciences
Court 11, Satellite building 8,
Brayford Pool, Lincoln
LN6 7TS

Dear Miss Mannix

I am writing to confirm that the following study is authorised to take place within our Trust:

Title: Implicit Theories in High Secure Male Mentally Ill Child Sexual Offenders

Directorate(s): Mental Health, Rampton

Start Date: 3rd February 2009 **End Date:** 1st September 2010

Outline: To conduct a semi-structured qualitative interview with approximately eight mentally ill child sex offenders, to examine the implicit theories held by this group.

We wish you well with your work. In accordance with the Research Governance framework, The Trust RMG Department follows up such work to assess its impact and influence on practice and policy. You will receive a brief progress report form to complete six months after the start of your study which will provide you with the opportunity to let us know of any problems you may be having. We will also ask you for some information at the end of your study.

Please keep this letter with you during the course of your research to confirm that you have Directorate and RMG Dept. approval, to gain access to the areas where your research is taking place. If you or others have

concerns they can contact the RMG department on 0115 9934543 or mobile 07747 030196 or by email to jayne.simpson@nottshc.nhs.uk.

Yours sincerely

Jayne Simpson MSc
On behalf of Prof Chris Evans and Trust RMG Department

Extended Paper

Extended Introduction

There is an abundance of research on the aetiology and maintenance of child sexual offending. Existing theories have emerged from research which has typically not involved mentally disordered child sexual offenders and includes psychodynamic, feminist, cognitive behavioural and biological theories. Researchers have argued that the major flaw in most of these theories is that they have attempted to explain child sexual abuse with one single theory (Finkelhor, 1984; Marshall & Barbaree, 1990). Finkelhor (1984) argues that the diverse nature and range of sexually abusive behaviours cannot be adequately explained by one factor alone and proposed the need for multi-factorial explanations to try and establish the motivating factors that guide an adult male to have sexual relations with a child, and the sustaining factors that contribute to the maintenance of such relations. The most influential of these are Finkelhor's (1984) Precondition Theory, Marshall and Barbaree's (1990) Integrated Theory, Hall and Hirschman's (1992) Quadripartite model of child molestation and Ward and Siegert's (2002) Pathway's Model. They propose many factors as being influential in the genesis and maintenance of child sexual offending, including distorted cognitions, deviant sexual arousal (Finkelhor, 1984), insecure attachments and intimacy problems (Ward & Siegert, 2002), emotional regulation problems (Ward & Siegert, 2002), and offence supporting attitudes (Hall & Hirschman, 1992). Distorted cognitions and the underlying structures which are thought to generate them, implicit theories, are the focus of this study, Particularly the cognitive distortions and implicit theories of child sexual offenders with a mental disorder (i.e. mental illness and/or personality disorder) as these have received little attention in the sexual offender research.

These aetiological models guide treatment interventions for sexual offenders and the most common treatment approach appears to be cognitive behavioural (e.g. Howitt, 1995). This model assumes cognitions play a key role in determining behaviour. Beyond this theories of the role of cognition are hard to find (Mann &

Beech, 2003) with research focusing almost entirely on the measurement and content of offence supportive attitudes and beliefs. Despite the need for a more theory-driven approach, in particular differentiating cognitive structures from cognitive products (Ward, Hudson, Johnston & Marshall, 1997), it is only recently that researchers are moving away from the measurement approach (Ward, 2000). Ward and colleagues are one of the first to develop a more coherent account of cognitive distortions in child sexual offenders using the Implicit Theory approach. It is important to remember that in understanding any behaviour, not least criminal behaviour, multiple factors will underpin and motivate the individual, including personality traits, fluctuating psychological states, and circumstantial and situational factors. Within such a multi-factorial model of behaviour, cognition is only one factor to be considered in a multi-factorial theory of child sexual offending.

Prior to looking at the method and results of this study, cognitive factors proposed as influential in child sexual offending (e.g. cognitive distortions, schemas and implicit theories) will be discussed. Research evaluating cognitive distortions will be examined before giving consideration to schemas and implicit theories and how they have been applied in the domain of sexual offending. Particular attentions will be paid to the distinct child sexual offenders' implicit theories proposed by Ward and Keenan (1999). Finally, the limited research concerning child sexual offenders with a mental disorder is discussed. Since the majority of sexual offenders against children are male (Langton & Marshall, 2001), this paper is concerned with male child sexual offenders only.

Cognitive Distortions in Sexual Offending

A growing body of research since the 1980s has explored the role of cognition in the genesis and maintenance of child sexual offending. This research has shown that child sexual offenders hold thoughts and beliefs that justify their sexual offending of and appear to facilitate and maintain their sexual offending behaviours (Gannon, Ward & Polaschek, 2004; Ward et al., 1997). The term 'cognitive distortions', originally used by Beck (1963) in reference to the intrusive thoughts associated with depression, was first used in the sexual offending domain by Abel,

Becker and Cunningham-Rather (1984). Abel and his colleagues (1984; 1989) used social learning theory to propose that for some unidentified reason, some men fail to inhibit sexual arousal to stimuli that may be associated with deviant sexual interests (Gannon & Polaschek, 2006). Consequently, they develop into adult men with deviant sexual interests and behaviours. Abel and colleagues propose that in order for these men to cope with the disparity between their sexual preferences and societal norms, they develop sexual offence supportive beliefs that function to justify their sexual preferences and reduce their feelings of guilt and shame. Abel labeled these beliefs 'cognitive distortions'.

Cognitive distortions have been viewed as fundamental thinking errors that hinder an individual's ability to make realistic formulations and interpretations of their reality (Freeman, Pretzer, Fleming & Simon, 1990). According to Howitt (1995), cognitive distortions provide the offender with an interpretive framework that allows them to justify, rationalize, and essentially excuse their maladaptive behaviours to themselves and others. Murphy (1990) proposed cognitive distortions are protective mechanisms that allow the offender to distance himself psychologically from his abusive actions. He describes three types of processes that he believes child sexual offenders use to deal with incoming information: (a) justification of acts in terms of morality or psychological necessity, (b) minimization of harm or misattribution of consequences, and (c) shifting responsibility from themselves by devaluing victims. Related to this is the observation that some child sexual offenders fail to fully recognize the harm caused to their victims because of their behaviour (Hanson, Gizarelli & Scott, 1994; Salter, 1988; Ward, Hudson & Marshall, 1995). Kennedy and Grubin (1992) have contended that the explanations given by sexual offenders provide a defence against loss of self-esteem, and perhaps for others it may be a search to make sense of their offending.

Rapists and child sexual offenders are thought to hold distinct cognitive distortions (e.g. Hanson et al., 1994). Child sexual offenders are hypothesised to hold beliefs that legitimise sexual relationships with children, view sexual activity as being beneficial to children, and to view adult-child sex as socially acceptable (e.g. Abel

et al., 1984; Gore, 1988). Examples of such statements include “children enjoy sexual contact with adults”, “sex is good for children” (Abel et al., 1984; Ward, 2000; Ward et al., 1997).

Research examining cognitive distortions in child sexual offending

Abel and colleagues (1984; 1989) were the first to document cognitive distortions commonly articulated by child sexual offenders. They observed that offenders often made statements indicating they perceived the child victims as being willing sexual partners, who instigated and enjoyed the experience. Other statements indicated that the offenders viewed their behaviour as acceptable and harmless for different reasons (e.g. having sex with a child is educational; only touching a child’ body or genitals is not really being sexual so no harm is done). The techniques used to elucidate these themes appear to have been largely anecdotal and obtained through clinical experience (Gannon, Ward & Collie, 2007).

Since Abel’s work, researchers have employed more formal techniques to expand upon the list he generated. Stermac and Segal (1989) used a vignette approach to describe sexual contact between an adult and a child. They found that child sexual abusers differed from adult sexual offenders and non-offending participants in that they perceived more benefits to the child as a result of the sexual contact, greater complicity on the child’s part, and less responsibility on the adult’s part. Stermac and Segal (1989) proposed child sexual offenders interpretation of sexual information in maladaptive ways served as either a contributory or facilitating factor in their subsequent offending behaviours.

Neidigh and Krop (1992) used a semi-structured interview with 101 male outpatient child sex offenders who were undergoing psychotherapy for their offending. Three hundred and fifty-seven statements were generated which were sorted into 38 cognitive distortion categories. Some resembled Abel et al.’s (1984) previous observations but new categories also emerged (e.g. I can’t control myself so I’m not responsible”). These findings appeared to reaffirm the ‘excuse themes’ formulated by Pollock and Hashmall (1991). In a study examining over 250 statements collected

from clinical records of 86 successive child sexual abusers referred for psychiatric assessment, Pollock and Hashmall (1991) derived six "excuse themes" including: mitigating factors (situational); sex with children is not wrong; incident was nonsexual; mitigating factors (psychological); blaming the victim; and denial.

Kennedy and Grubin (1992) conducted structured interviews with 102 convicted incarcerated sexual offenders, 66 of whom were child sexual offenders, in order to identify patterns of denial, and develop offender typologies based on these. Subjects' own accounts of their offending were rated on degree of denial and different themes for their offending (e.g., internal and external attributions). One third of the men denied any involvement. Those who admitted did not accept full responsibility and either blamed the victim, claimed an abnormal internal state (e.g., offence was out of character), or blamed third parties. Only one-third viewed their actions as harmful to their victim.

In their New Zealand study assessing 26 incarcerated male child sexual offenders, Ward, Hudson and France (1993) asked subjects to give their "reasons" for offending at three different points on their most typical offence scenario. Reasons were sorted according to categories including sexual, negative affect, positive affect, dominance/anger, intimacy, helping, and other. Overall, a significant number of men gave sexual motivation as their primary reason for sexual offending, followed by the need for intimacy.

Hanson et al. (1994) investigated the differences between incest offenders and two comparison groups, male batterers and a community group, in regard to their cognitive distortions. Results showed that incest offenders were more likely to perceive children as being sexually attractive, to minimize the harm to the victim and to endorse male sexual entitlement.

Using grounded theory, Hartley (1998) identified the main themes emerging from incestuous child sexual offenders' offence descriptions. He found offenders attempted to reduce their responsibility for the offence by claiming that the child could control the sexual interaction, that the abuse was a game, or that the abuse

had not harmed the child. Offenders also used to child's lack of resistance to justify their actions. Saradjian and Nobus (2003) also used grounded theory to identify distorted cognitions from the therapy files of clergy child sexual offenders. They identified ten types of offence supportive cognitions that occurred throughout the offence. Prior to offence, the offenders tended to believe that their sexual offending would meet important needs, would be ethically acceptable, and would not be long lived. At the time of the offence, the child sexual offenders felt their offending would be harmless and the child was responsible in the offence. Post offence, the offenders minimised the seriousness of their behaviours, externalised responsibility, focused on positive personal attributes and made reference to previous undetected offences to justify their continued offending. This is consistent with other researchers who have described cognitive distortions as being present throughout the whole offence process, and asserted that the type of cognitive distortions used by an offender is specifically associated with their function at a particular stage (Ward, Fon, Hudson & McCormack, 1998; Murphy, 1990).

Critique

Starting with the work of Abel and his colleagues (1984; 1989), a major criticism of this research is that their definition and conceptualization of cognitive distortions was broad and ambiguous and has left significant room for interpretation (Gannon et al., 2007). Gannon and Polaschek (2006) argue that Abel's failure to precisely define this term is reflected in the lack of a consistent operational definition of the term in the literature that followed. For example, researchers have used cognitive distortions with 'maladaptive belief' (Ward et al., 1997), as well as using it to refer to rationalizations, excuses and justifications (Neidigh & Krop, 1992). Gannon and Polaschek (2006) argue there is a lack of clarity concerning whether cognitive distortions represent a permanent belief structure or temporary cognitions used to facilitate and justify sexual offending behaviour. Mann and Beech (2003) also criticize Abel and his colleagues for the lack of clarity around the accessibility of cognitive distortions, arguing individuals could use them consciously to avoid judgment by others, or they could emerge automatically as a defense mechanism.

They also argue that the function of cognitive distortions is unclear and this role ambiguity exists today. Some argue they serve as precursors to offending (e.g. Finkelhor, 1984; Hartley, 1998), while others suggest they act as post offense self-esteem maintenance strategies (e.g. Murphy, 1990). The reality for most offenders may be that both of these positions are true (Ward, Keenan & Hudson, 2000).

More recently, Drake, Ward, Nathan and Lee (2001) and Ward (2000) point out that there is no theoretical basis underlying the distortions presented by Abel and researchers. They argue that, along with other researchers, they have typically focused on the content of the cognitive distortions, discussing them as if they exist independent of one another (Drake et al., 2001). This is incongruous with other psychological literature which has attempted to develop a theoretical account of the mechanisms generating these cognitive distortions (e.g. developmental literature relating to implicit theories and social cognition literature relating to schemas). This raises the question as to whether examining these underlying structures would be of more relevance in deepening our understanding of cognitive distortions; of how they arise, how they occur and their link to sexual offending (Milner & Webster, 2005).

Schemas in Child Sexual Offending: A review of current research

The schema approach to sexual offending (Mann & Beech, 2003) arose out an attempt to provide a more comprehensive and coherent account of child sexual offenders' cognitive distortions than that provided by Abel and colleagues (1984; 1989). Mann and Beech (2003) define schemas as 'structures in memory in which prior knowledge and experiences are organised' (p.138), which contain 'attitudes, ideas about the self and the world, specific beliefs, conditional assumptions, and core issues' (p.140). They are categories of prototypical entities created over time in response to the multitude of stimuli individuals come across. They allow for efficient processing of information by simplifying and classifying information based on past experiences and knowledge (Mann & Beech, 2003).

To date, investigation of the cognitive schemas and processing of sexual offenders is extremely limited. Although some useful empirical investigations have been done and theoretical research is growing, a review of the literature by Mann and Beech (2003) demonstrates that much of the research has focused predominantly on adult male sexual offenders (e.g. Malamuth and colleagues, 1994; 1991). There are no existing studies which discuss schemas in mentally ill and/or personality disordered child sexual offenders.

Research examining Schemas in Sexual Offenders

Myers (2000) compared 'life maps' of rapists, child molesters and non-sexually violent offenders regarding themes to do with their views of themselves and the world. Different patterns were found among the three groups: Rapists showed clear schemas involving a distrust of women and a need for control. Sexual entitlement figured for rapists more than child molesters and not at all for violent offenders. Child molesters, in contrast, showed schemas more related to worthlessness and passive victim stance. This finding was supported in later research by Milner and Webster (2005). They examined the schema content in violent offenders, rapists and child sexual offenders and found the most prominent theme for child sexual offenders to be 'a sense of worthlessness'. They relate this finding to literature that reports the presence of low self esteem in child sexual abusers.

Mann and Hollin (2001) also used a qualitative approach and carried out two investigations into schemas in adult sexual offenders before widening their investigation to include child sex offenders. The idea of a grievance schema and a control schema was found in both studies, although the schemas were much more noticeably observed in the accounts of the rapists than they were in the accounts of the child offenders.

Critique

The schema approach has clear advantages over Abel's earlier explanation of cognitive distortions, providing a framework which organizes and shows the interrelatedness of cognitive distortions. However, Ward (2000, p.494) argues the

utility of the schema construct is limited by the ambiguity of the term. He points out that it has been used to refer to a number of mental constructs, including categories, behavioural scripts, beliefs or explanatory theories. In addition to this, Ward (2000) argues it remains unclear as to how maladaptive schemata develop from negative developmental experiences and emerge in offenders. Furthermore in terms of scope, the schema model appears to be somewhat limited. Mann and Hollin (2001) suggest there are many offence related cognitions articulated by child sexual offenders, which are different from those seen in other offenders (e.g. worthlessness), that it does not account for.

Ward (2000) proposed thinking of schemata as 'implicit theories', similar to scientific theories which are used to explain, predict and interpret interpersonal phenomena. He argued an implicit theory approach is broader than the schema approach. This view is supported by Thakker, Ward and Navathe (2007) who propose the schemas delineated by Mann and others are subsets of implicit theories (e.g. abandonment instability schema refer essentially to uncontrollability). Given the broad definitions of implicit theories, Ward (2000) argues it can further our understanding of cognitive distortions.

The Implicit Theory approach to Sexual Offending

Ward and his colleagues (Ward, 2000; Ward & Keenan, 1999) used the notion of implicit theories to try and provide a framework for conceptualizing sexual offenders' cognitive distortions. Prior to considering how Ward (2000) applies this construct to the domain of child sexual offending, the reader will first be provided with a description of the nature of implicit theories in psychology. The five distinct implicit theories hypothesised by Ward and Keenan (1999) to describe the thinking of child sexual offenders will then be discussed.

Implicit Theories in Psychology

Researchers in developmental, personality and cognitive psychology have argued that understanding and explanation is underpinned by Implicit Theories. Implicit

theories are defined as personal constructions about particular phenomenon that reside in the minds of individuals (Sternberg, Conway, Ketron & Bernstein, 1981). They function like scientific theories and are used by people to explain and interpret interpersonal events (e.g. the behaviour of others) and to increase their capacity to explain, predict and control their world.

The implicit theory hypothesis is based on developmental psychology research, which views cognitive development as being driven by a generation of implicit theories in a given domain (Gopnik & Meltzoff, 1997). At approximately 4 years of age, children are hypothesised to begin to develop a theory of mind and organize knowledge into theories (Gopnik & Wellman, 1994). These theories enable them to explain and understand aspects of their social world, as well as their behaviour and the behaviour of others. They are seen to act as a scientist, forming hypothesis, testing them out and discarding those that fail to predict behaviour (Drake et al., 2001). They come to understand that the actions of others can be predicted if there is information available about that person's beliefs and desires (Ward, 2000). Thus, the child's understanding of other peoples' mental states progresses through the development of increasingly adequate understandings of the mind, i.e. implicit theories. Implicit theories therefore develop as a way of organizing knowledge about the environment, and assist people in understanding and making predictions concerning the self, others, and the world (Dweck, Chiu & Hong, 1995; Gopnik & Metzoff, 1997).

Ward (2000) views implicit theories as functioning in a similar way as scientific theories insofar as they are used to explain phenomena, to make predictions about the future, and like scientific theories, they are also seen as being interconnected. However, he points out that unlike scientists who strive to evaluate evidence from an objective stance, humans generally make interpretations based on their theories. Thus, implicit theories are self-fulfilling and guide the interpretation of incoming information so that supportive information is highlighted and evidence that is inconsistent with an existing theory is discarded or reinterpreted to fit with that

theory (Gopnik & Meltzoff, 1997). Implicit theories are influenced, in part, by cultural traditions and expectations (Runco & Johnson, 2002) and are found to be highly stable over time (Ward, 2000).

Social and cognitive psychologists have studied peoples' implicit theories in a variety of domains, including everyday views of intelligence (Berg & Sternberg, 1992; Dweck & Elliott, 1983), interpersonal and romantic relationships, creativity (Chan & Chan, 1999; Puccio & Cheminto, 2001), the role that implicit theories play in social information processing (McConnell, 2001) and stereotype formation (Levy, Stroesser & Dweck, 1998). Ward (2000) has recently applied the implicit theory approach to the domain of sexual offending.

Implicit Theories in Child Sexual Offending

Ward (2000) and Ward and Keenan (1999) argue that child sexual offenders cognitive distortions are the product of implicit theories that the offender uses to make sense of themselves, their victims and their world. Ward (2000) proposes offenders develop these implicit theories developed during a childhood of adversity (e.g. physical abuse, neglect) as the offender tries to understand and make sense of such negative events. However, the content of offenders' implicit theories is hypothesised to be maladaptive and influences the child sexual offender to attend to, perceive and interpret their social world in offence congruent ways (Ward, 2000).

As the content of implicit theories is hypothesised to influence how an offender interprets experiences, Ward (2000) proposes a sexual offender' implicit theories will influence him to attend to and interpret his victim's behaviour in distorted ways. The suggestion is that sexual offenders' implicit theories concerning their victims are structured around two core sets of mental constructs: beliefs, and desires. An offender's theory of a victim therefore, contains a representation of the victim's desires (needs, wants, preferences), beliefs, and attitudes (Ward, 2000, p. 498). The victim's behaviour is interpreted by the offender using this framework, which leads him to act (Ward & Keenan, 1999).

As mentioned above, implicit theories dictate what counts as evidence and how this is interpreted. If there is a discrepancy between an offender's implicit theory and the evidence, the offender is likely to reinterpret the evidence to fit his assumptions. For example, if an offender thinks a child wants sex, he is likely to seek out sex with the child and perceive this as what the child wanted. Such an implicit theory can also lead to a child's everyday behaviour being interpreted in sexual terms. For example a child sitting on an offender's knee could be interpreted as revealing sexual preferences and may generate distorted statements such as 'the child sought sex out' (Ward & Keenan, 1999). Offenders are also likely to choose environments which support their implicit theories, for example, other child sexual offenders (Ward & Keenan, 1999). Rarely will the offender's implicit theory be modified. Ward and Keenan (1999) explain how child sexual offenders will account for 'anomalous' observations by minor adjustments within the offender's implicit theory, such as "this child is different to most other children". A replacement theory will only be applied if there is consistent counterevidence outweighing the offender's existing hypothesis (Ward & Keenan, 1999)

Child Sexual Offenders' Implicit Theories

Examining relevant existing questionnaires and previous research, Ward and Keenan (1999) hypothesised that child sexual offenders hold five distinct implicit theories which account for the majority of their cognitive distortions, and which they use to make predictions about the meaning of children's behaviour and underlying desires and intentions. It is likely that only a subset of these implicit theories will be present in any given child sexual offender (Drake et al., 2001). In those offenders who hold more than one, Ward (2000) proposes their implicit theories will be grouped into a number of general content areas (e.g. an offender who views children as sexual beings may also view himself as being superior to the child and in charge). Ward (2000) also suggests that different types of offenders (e.g. extrafamilial / incestuous child sexual offenders) may hold different implicit theories and their representative cognitive distortions can be used to differentiate them from one another.

The five distinct implicit theories proposed by Ward and Keenan (1999) to underlie the majority of child sexual offenders cognitive distortions include:

Children as sexual beings

Ward and Keenan (1999) hypothesise that child sexual offenders with this theory believe children to both need and desire sex. Children are perceived as active seekers of sex who have the capacity to make informed decisions regarding sex with adults. Individuals, including children, have a right to express their sexual needs. It is natural to allow expression of such needs. They are likely to consider sexual activity to benefit the child, with children's everyday behaviour often being interpreted as having sexual connotations or revealing sexual intent. A statement representative of this theory may include "*the child seduced me"* or "*children are curious about sex and enjoy it*" (Ward & Keenan, 1999, p. 832).

In their study of child and adult sexual offenders and non-offending participants, Stermac and Segal (1989) found support for this theory. Their sample of child sexual offenders reported more rewards for the child in having sex, more responsibility to the child and less adult responsibility for the abuse than either of the other two groups. Saradjian and Nobus (2003) and Marziano, Ward, Beech and Pattison (2006) also found further evidence of offenders' statements supporting the belief that children desire and want sex.

Nature of Harm

This theory can be present in child sexual offenders in two ways. Those who hold the first variant are hypothesised by Ward and Keenan (1999) to perceive harm along a continuum ranging from minor to major. They do not feel that sexual activity alone is harmful for children and often argue there are other more harmful behaviours that a child could experience. For example, physical aggression, or more intrusive sexual behaviours (e.g. full penetration, sexual acts involving force). Ward and Keenan (1999) hypothesise that offender's holding the second variant of this theory view sex as a harmless activity which does not have any damaging

effects on a child. A statement representative of this theory may include "*sex between a child and adult isn't harmful*" or "*it was only a bit of fun anyway*" (Ward & Keenan, 1999, p. 832)

Other research has supported this theory. As previously mentioned, Stermac and Segal (1989) found that compared to adult sexual offenders and non-offending participants, child sexual offenders reported more rewards and less harm for a child in having sex with adults. In their sample of clergy child sexual offenders, Saradjian and Nobus (2003) found that their sample often made statements supporting the belief that they had not hurt their victims. Marziano et al. (2006) also found further evidence of this theory in their qualitative study using interviews with male child sexual offenders. They found this theory to be present in 10% of their sample.

Uncontrollability

This implicit theory is based on the belief that the world (including emotions, thoughts and events) is essentially uncontrollable, and that behaviour occurs based on factors out of one's direct control (Ward & Keenan, 1999). Offenders articulating cognitive distortions associated with this theory are not thought to see themselves as being in control of their lives and attribute their offending to both powerful internal and external factors (i.e. the victim; their environment; drugs) which shape their existence. An example of a cognitive distortion representative of this theory may include "*A lot of time sexual assaults are not planned, they just happen"* or *"I was high on drugs and alcohol at the time"* (Ward & Keenan, 1999, p 831).

Additional support for this theory has been provided by other researchers. Marziano et al. (2006) found that 26% of their sample attributed their offending to external factors which were outside their control. Saradjian and Nobus (2003) also found similar results in their study on clergymen who abused children.

Dangerous World

Ward and Keenan (1999) propose that child sex offenders demonstrating support for this implicit theory see the world as a hostile place and view people, particularly adults, as threatening. The offender will often believe he has to fight to protect himself and achieve dominance and control over others he considers to be threatening before he is exploited, degraded or deceived by them (Ward & Keenan, 1999). In particular, sexual abuse of others protects the offender against him being the victim. Some offenders holding this theory may view both adults and children as hostile and exploitive. For other child sexual offenders holding this theory, there is a strong focus on the unreliability of adults and the dependency of children (Ward & Keenan, 1999). Children are reported to be seen as more accepting and trustworthy, who can provide offenders with love and care and who will put the offender's needs before their own. Examples of statements representing this implicit theory may include "*You can't trust adults"* and "*children are innocent and want to please adults*" (Ward & Keenan, 1999, p. 830).

Since Ward and Keenan's (1999) study, further evidence has been found for this theory. Marziano et al. (2006) found that 22% of their sample made statements supportive of this implicit theory.

Entitlement

Ward and Keenan (1999) hypothesise that child sexual offenders holding this implicit theory are likely to see themselves and their needs as being paramount in comparison to other less worthy groups of people, including children. Thus, they believe their needs, including sexual needs, should be met on demand. Consequently, these offenders feel they are entitled to have sex when they want to and with whom they want, even a child. Furthermore, they feel justified in punishing a child who is not suitably subservient to their needs (Ward & Keenan, 1999). An example of this is "*I'm the boss in this family*" or "*I created her she is mine*" (Ward & Keenan, 1999, p. 829).

Since Ward and Keenan's (1999) study, further evidence has been found for this theory. In their study, Marziano et al. (2006) found 10% of their sample made statements reflecting this implicit theory. Saradjian and Nobus (2003) also found support for this theory in their study, as did Hartley (1998). He reported that in his sample of incestuous offenders, they appeared to perceive their sexual offending as their right due to them being the child's father.

Critique

In comparison to Abel and colleagues earlier findings (1984; 1989), Ward's (2000) implicit theory approach demonstrates good explanatory depth, detailing more fully and in a more coherent manner the origins of how maladaptive beliefs develop (i.e. during an abusive childhood). Ward's (2000) approach also appears to be more focused than Abel's and his conceptualisation of cognitive distortions is much narrower and firmer, limiting his hypotheses to the maladaptive belief mechanism associated with cognitive distortions (Gannon et al., 2007).

Implicit theories are another way of conceptualizing schemas. The definitions of both terms given by the authors suggest they are referring to the same type of psychological construct. However, Ward (2000) is careful to point out that implicit theories have a clear functional role in helping individuals interpret and explain events in their internal and external world. This approach is more fully explicated as a theory as implicit theories are explained and conceptualized in relation to scientific theories. By organizing various cognitive distortions into implicit theory categories, it attempts to explain their interrelationships. Furthermore, it has greater breath insofar as it appears to cover more of the cognitions exhibited by child sexual offenders.

Ward and Keenan (1999) consulted a number of measures, as well as relying on their clinical experience, in identifying the five distinct child sexual offenders' implicit theories. However, they do not make clear what information comes from which measure (Gannon, Keown & Rose, 2009). Ward and Kennan (1999) state that their proposed implicit theories account for all the cognitive distortions in the measures

and research papers they reviewed. It could be concluded from this that other cognitive distortions exist, which Ward and Keenan (1999) have not included and which are consequently not covered by these five implicit theories. Additionally, empirical support for Ward and Keenan's (1999) themes is also somewhat unclear. Although some studies have found evidence for many of these themes (e.g. Marziano et al., 2006; Mihailides, Devilly & Ward), others have not (e.g. Gannon, Wright, Beech & Williams, 2006). Thus, empirical evidence supporting the implicit theory stance must be built upon before empirical support for this approach in sexual offender research and treatment can be fully established.

Summary

The implicit theory approach is founded on the idea that underlying core beliefs can give rise to a large number of cognitive distortions. As the evidence suggests, all the implicit theory research has been carried out on incarcerated child sexual offenders or community based samples that were not identified as having a mental illness or a personality disorder. Whether evidence of Ward and Keenan's (1999) hypothesised five child sexual offender implicit theories will be found in these sexual offenders has not yet been explored. Researchers have proposed that to reduce recidivism, it is vital to assess and treat these underlying implicit theories rather than simply identifying their individual surface level cognitive distortions (e.g. Mann & Beech, 2003; Ward, 2000). In view of this, the implicit theories of mentally disordered sexual offenders require attention.

The Literature on Sexual Offenders with a Mental Disorder

In contrast to the abundance of literature on the aetiology and maintenance of child sexual offending in general, research concerning child sexual offenders with mental disorders is somewhat limited. In comparison to child sexual offenders with a mental illness, there currently exits a large body of research detailing the characteristics and treatment of the personality disordered sexual offender. This has led to the development of assessment and treatment models for these sexual

offenders (Murray, Briggs & Davies, 1994). Child sexual offenders with a mental illness, however, have tended to be dismissed as a small and irrelevant category (e.g. Craissati & Hodes, 1992; Chesterman & Sahota, 1998; Smith, 2000), with few guidelines on their assessment, treatment and background.

Despite evidence indicating that child sexual offenders have high levels of cognitive distortions, little is known about the role of cognition in mentally disordered child sexual offenders. The majority of the studies on child sexual offenders with a mental illness have focused predominantly on adult sexual offenders with a mental illness. Additionally, the relationship between their psychotic symptoms and offending has been the main focus of inquiry, with little attention being given to their cognitive distortions and implicit theories. Research concerning the personality disordered sexual offender also lacks an understanding of their implicit theories, with the majority of studies focusing on the characteristics of these offenders and the relationship between specific personality disorders and sexual offending. The limited literature on these offenders will now be discussed.

Child Sexual Offenders with a Mental Illness

Child sexual offenders with a mental illness are a poorly studied group. One explanation for this may be due to the relatively low rates of sexual offences among the mentally ill in general (Alish et al., 2007). Packard and Rosner (1985) found the rates of sexual offences in individuals with schizophrenia to range from 2 to 5%. This small percentage is consistent with psychiatric research (Smith, 1999) which does not report a strong relationship between sexual offences and psychiatric disorders (e.g. Kafka & Hennen, 2002; Murray et al., 1994). This suggests a small number of mentally ill patients commit sexual offences.

Although the mentally ill constitute a small minority of sexual offenders, they are significant in terms of forensic populations. Baker and White (2002) reported a rise in the number of sex offenders detained in maximum security hospitals according to Home Office statistics. Other researchers have also documented that within regional forensic services, mental illness appears to be the most common

diagnosis amongst patients in general (Coid, Kathan, Gault, Cook & Jarman, 2001; Edwards, Steed & Murray, 2002) and sex offenders in particular (Chesterman & Sahota, 1998; Craissati & Hodes, 1992). Alvarez and Freinhar (1991) found higher rates of deviant sexual fantasy and behaviours among patients with a mental illness relative to non-mentally ill individuals. Wallace et al. (1998) also found that violent offenders diagnosed with schizophrenia are approximately four times more likely to have been convicted of a serious sexual offence than their non-mentally ill counterparts. Despite their high numbers in high security hospitals, sexual offenders with a mental illness are a relatively neglected group in the literature on sexual offenders.

The limited research on sexual offenders with a mental illness may also be related to the belief that sexual offending in the context of mental illness occurs solely due to the psychotic symptoms and attempts to develop theories and typologies to explain the relationship between mental illness and sexual offending (e.g. Dietz, 1992; Smith, 2000) have typically considered the presence of mental illness alone to be an adequate explanation (Sahota & Chesterman, 1998). However, such beliefs are in contradiction to existing studies which suggest that symptoms of mental illness alone do not sufficiently explain sexual offending, supporting the view that sexual offender pathology, such as cognitive distortions and intimacy problems, are contributing factors (e.g. Craissati & Hodes, 1992; Sahota & Chesterman, 1998; Smith, 1999). Consequently, these theories have been insufficient to explain the sexual offending of these offenders, lacking a more general understanding of the possible mechanisms underlying these sexual offending behaviours (Drake & Pathe, 2004).

More recently, Drake and Pathe (2004) developed a typology of mentally ill sexual offenders in an attempt to acknowledge the complex relationship between mental illness and sexual offending. They proposed that sexual offenders with a mental illness can be divided into 4 groups: (1) those with pre-existing deviant sexual activities/interests; (2) those with deviant sexuality arises in the context of mental illness and/or its treatment; (3) those whose deviant sexuality is a manifestation of

more generalised antisocial behaviour, and (4) factors other than the above (e.g. acquired brain damage, dementia, substance misuse). These typologies offer a useful framework for evaluating and treating sexual offenders with a mental illness. However, they do not advance our understanding of the many different factors associated with sexual offending (e.g. cognitive distortions and implicit theories), nor do they appear to address the heterogeneity of adult and child sexual offenders.

There is a complex relationship between mental illness and sexual offending and although they are a small group, this complexity means they require a high level of resources to receive adequate assessment and treatment (Drake & Pathe, 2004). These studies will now be discussed.

Research examining the relationship between sexual offending and psychotic symptoms

Existing research does not provide unequivocal conclusions regarding the relationship between sexual offending and mental illness. While very limited, some data exists to suggest that sexual offenders with schizophrenia represent a group similar to non-mentally ill sexual offenders. For example, Sahota and Chesterman (1998) carried out a study on 20 adult males detained in a UK regional secure unit, of whom seventeen had a diagnosis of schizophrenia and an index offence of rape or indecent assault. The results revealed similarities between mentally ill and non mentally ill sexual offenders, both receiving low scores on measures of self esteem, sexual knowledge and high ratings for cognitive distortions, sexual obsession, sexual dysfunction and faulty sexual knowledge and beliefs. Chesterman and Sahota (1998) also reported on 20 male sex offenders with a mental illness diagnosis, 12 of whom were considered by their psychiatrists to have been psychotic at the time of their offending. Seven of the 12 men admitted experiencing delusions and hallucinations at the time of their offences but did not feel these symptoms were directly related to their offending. Instead, they explained their sexual offending by revenge, sexual frustration, anger and arousal.

In a series of articles, Smith and Taylor (1999) and Smith (2000) examined the relationship between the adult sexual offending and the psychotic symptoms of 80 male restricted hospital order patients. All of these men had been convicted of a contact sexual offence against a woman whilst psychotic, however specific delusional or hallucinatory drive were reported in only a minority of cases. This suggests that other factors contributed to sex offending in this group of men. They concluded that similar to sexual offenders in general, personality and cognitive factors, as well as the use of alcohol and other substances of abuse, were leading factors in the offences. Greenall and Jellicoe-Jones (2007) also found that although psychotic drive was a factor in the sexual offending of their sample of mentally ill sex offenders, the results also indicated that sexual violence was primarily motivated by other factors such as anger/violence, sexual disinhibition and paedophilia. However, medication was the primary treatment intervention, with no treatments aimed at addressing other motivational or risk factors.

Other studies, however, have challenged these finding suggesting that the offending behaviours of sexual offenders with a mental illness are dictated to some extent by the symptoms of their mental illness. Crasssati and Hodes (1992) carried out a descriptive study of 11 regional secure male patients who had been convicted of sexual offences against women. Ten had a diagnosis of schizophrenia. Craissati and Hodes (1992) found the patients' sexual offences were impulsively executed occurring in the early phase of their illness with little thought given to potential capture. They found the offending to be primarily triggered by feelings of sexual disinhibition. They suggested mental illness broke down a person's normal inhibitory controls and left them unable to look beyond their immediate aim, to the nature and consequences of their actions. Re-offending behaviour was predominantly associated with relapse. None of their sample had a history of delinquency, violent nonsexual offences, or alcohol abuse. From their study, Craissati and Hodes (1992) concluded that the mentally ill sexual offenders are not 'akin to the sociopathic type cited in the literature' (p. 848).

Jones, Huckle and Tanaghow (1992) described 4 male schizophrenic patients who attempted, and in one case succeeded, in sexually abusing young women. Their offending was explained as a response to their auditory hallucinations. Although there is evidence to suggest that some individuals frequently obey and act on their command hallucinations (e.g. Chadwick & Birchwood, 1994), in light of the limited information regarding the participants' of this study and their criminal and psychosexual history, conclusions regarding the relative importance of different phenomenology and sexual offending are tentative.

Summary

In the context of sexual offending and mental illness, the literature describes a variable relationship between sexual offending and mental illness, with psychotic symptoms alone being insufficient to explain it. Patients included in the study by Craissati and Hodes (1992) were not floridly psychotic at the time of their sexual offending but their mental illness was found to act as a possible disinhibitor. On the other hand, Jones et al. (1992) described four patients whose psychotic symptoms (e.g. auditory hallucinations) was thought to contribute directly to their sexual offending. Smith (2000) also described hallucinations and persecutory ideation as being influential in the sex offending of some of his sample, although he remarked on the similarity between mentally ill and non mentally ill sexual offenders in terms of their motivating factors (e.g. cognitive distortions). Although these groups are thought to share similar deficits, treatment of psychotic symptoms is often regarded as paramount (Greenall & Jellicoe-Jones, 2007). Consequently, further research is required to identify what factors beyond psychotic symptoms may be relevant when considering acts of sexual violence by the mentally ill and what treatment implications this may raise.

Child Sexual Offenders with a Personality Disorder

Personality serves regulatory functions of attention, selection, awareness and control of emotion, conscious thought and behaviour over time (Millon, 1996). Thus, it is not surprising that individual factors in personality (e.g. emotional regulation,

thinking styles) have been seen as helping to explain much of the behaviour of sexual offenders. Over the past 20 years, researchers studying personality disordered sex offenders have reviewed differences among sub-groups of personality disordered sex offenders, especially with regard to degree of psychopathology of the offender (e.g. Ahlemer, Kleinsasser, Stoner & Retzlaff, 2003) and personality characteristics (e.g. Bogaerts, Vervaeke & Goethals, 2004). There is only weak evidence, however, concerning this relationship between specific personality disorders and sexual offenders, with rapists found to show more antisocial and narcissistic personality disorders than child sexual offenders, who present as having more dependent avoidant and schizoid personality disorders (Seto & Barbaree, 1999).

Personality disorders have also been linked to sexual recidivism. A widely cited meta-analysis of sexual recidivism by Hanson and Bussiere (1998) found that the presence of any personality disorder was the only variable to significantly predict sexual recidivism. This was also replicated by Beggs and Grace (2008). In their sample of incarcerated child sexual offenders, they found that those with high scores on personality assessments were four times more likely to have been reconvicted of a sexual offence compared to other groups. Results were the same for extrafamilial and intrafamilial offenders when examined separately.

However, little is known about the aetiology of personality disorders and the relationship between personality disorders and the aetiology of child molestation. Attachment theory has been explored as one way of understanding the origins of personality disorders. Virtually all personality disorders are characterized by persistent difficulties in interpersonal relations, which are often central features (Birtchnell & Shine, 2000). Brennan and Slaver (1998) suggest that patterns of insecure attachment overlap with patterns of disordered personality in that they share similar developmental antecedents. Defining personality disorders as the final result of interpersonal processes, researchers have related personality disorders to insecure attachment styles (e.g. Jones, 1996) and specific parent-child interactions during the first years of life (Benjamin, 1993).

Consistent with this view, in their study of 84 intrafamilial and extrafamilial child sexual offenders, Bogaerts, Declercq, Vanheule and Palmans (2005) found that the offending of both groups was related to insecure attachments and personality disorders. Negative parental sensitivity in offenders was associated with negative relational attitudes and personality disorders leading to offenders lacking relational trust and being less capable of, and avoiding, engaging in intimate relationship (Jamieson & Marshall, 2001; Smallbone & Dadds, 2000). However, there is a lack of information about the linkage among the developmental antecedents of personality disorders to determine which personality disorders are shared by patterns of insecure attachment. Bogaerts, Vanheule and Desmet (2006) found schizoid personality disorder differentiated between their sample of securely attached and insecurely attached child sex offenders. The schizoid personality disorder has also been found in previous research to be a very strong predictor of child molestation (e.g. Bogaerts et al., 2004; Seto & Barbaree, 1999). Research has consistently shown that child sexual offenders experience less intimacy and friendship during child and adulthood than nonsexual and normal control groups.

Bogaerts et al. (2006) have drawn parallels between the description of the schizoid personality and emotional congruence and blockage in Finkelhor's (1984) theory. They propose that similar to schizoid individuals, child sexual offenders are frequently blocked from engaging in adult relationships by negative experiences with age appropriate adults, or limited/inadequate social and relational skills. Child sexual offenders feel more comfortable in relation to children and they are often emotionally congruent to children. Emotional congruence with children appears to have conceptual links with Ward and Keenan's (1999) Dangerous World implicit theory. However, as with the mentally ill offender, the implicit theories in personality disordered offenders has not been researched.

Summary

Personality disorders have been linked with sexual offending. In a comprehensive review of the literature, Marshall (1996) discusses diverse studies suggesting that sexual offenders possess mild to extreme difficulties in social skills and deficits in

cognition (e.g. Finkelhor, 1984). Many of these psychological deficits are consistent with etiological models of sexual offending and hallmark symptoms of major personality disorders. Some attempts have been made to measure personality disorders in sex offenders (e.g. Lehne, 2002), although the evidence fails to confirm any direct association between types of personality disorders and sexual offenders (Crassaiti, Webb & Keen, 2008). Whilst research also exists on the possible role of personality disorders in the aetiology and maintenance of sexual offending, little research has systematically examined the role of cognition and the impact of personality disorders on sex offending.

Rationale for the current study

Existing studies on child sexual offenders suggest that similar motivations have been found to underlie the offending behaviours of these men, regardless of diagnosis. Psychotic symptoms alone have been found to be inadequate explanations for sexual offending. Attributing sexual offending to symptoms of mental illness, or to the disinhibition caused by the illness, may lead to relevant factors such as social skills deficits, poor emotional regulation, deviant sexual fantasy and cognitive distortions being neglected as treatment targets. As mentioned at the start of this review, distorted cognitions have been afforded a key role by virtually all contemporary models of child sexual abuse and empirical studies have provided further evidence of their importance in the initiation and maintenance of child sexual offending behaviours (e.g. Finkelhor, 1984; Gannon et al., 2007). Although the role of cognitive distortions has been alluded to in child sexual offenders with mental disorders, there are no existing studies investigating the implicit theories in this population of child sexual offenders. A survey of existing literature on mentally ill sexual offenders using Medline and Science Direct from 1990 onwards did not find any empirical studies on the implicit theories of child (or adult) sexual offenders with a mental disorder. Consequently, it remains unknown whether these offenders articulate similar or different cognitive distortions to child sexual offenders in general, or whether their cognitive distortions are generated by the same distinct implicit theories hypothesised by Ward and Keenan (1999).

As previously mentioned, implicit theories have been advocated as a treatment priority for sexual offenders in general. Researchers have argued that addressing the individual surface level cognitions will not be effective as the underlying implicit theories which generate them will remain unchanged (e.g. Mann & Beech, 2003; Ward, 2000). Consequently, identifying and understanding the implicit theories of mentally disordered child sexual offenders is important in advancing both the assessment and treatment of this group, and in reducing their sexual offending behaviours. This is specifically relevant in light of existing studies which have linked personality disorders with recidivism and which have indicated that treatment of mental illness alone will not prevent further sexual offending. Thus, further exploration of the relationship between mental disorders and sexual offending is of direct relevance to clinical practice, risk reduction, as well as service provision.

Extended Research Aims and Hypotheses

Previous implicit theory studies have focused predominantly on incarcerated and community based samples of child sexual offenders. Given the identification of implicit theories in these populations, the current study sought to explore whether a UK sample of high secure male mentally disordered child sexual offenders would exhibit the same range of implicit theories. These include *Children as Sexual Beings, Nature of Harm, Uncontrollability, Dangerous World* and *Entitlement*. These theories are representative of thematic areas drawn by Ward and Keenan (1999) from the research literature on distorted cognition.

Investigating child sexual offenders who have a clinical diagnosis of mental illness and/or personality disorder will help ascertain whether previous findings from studies examining the implicit theories of general child sexual offenders are applicable to this group. It may also further our knowledge of whether diagnostic differences exist in relation to the type of implicit theory. For example, whether child sexual offenders with a personality disorder exhibit the same type of implicit theories held by those with a mental illness.

The current study is essentially an exploratory investigation. As such, no hypotheses were made. However, two specific research questions guided the investigation:

1. Will evidence of Ward and Keenan's (1999) five hypothesised child sexual offenders implicit theories, or new implicit theories, be found in a group of high secure child sexual offenders with a diagnosis of mental disorder?

2. Will diagnosis impact upon the type of implicit theories held by these offenders? For example, will child sexual offenders with a mental illness provide support for different or similar implicit theories to those suggested by child sexual offenders with a personality disorder?

Extended Methodology

Design

This study used a qualitative research design. Using a semi-structured interview, implicit theories in child sexual offenders with a mental disorder (e.g. mental illness and/or personality disorder) were explored. A qualitative methodology, content analysis (Weber, 1990), was employed to analyse the interview data and identify whether there was any evidence of Ward and Keenan's (1999) five hypothesised child sexual offenders' implicit theories, as well as evidence supportive of new implicit theories.

Rationale for a Qualitative Approach

Both qualitative and quantitative research methods are concerned with the individual's point of view. This study adopted a qualitative approach for different reasons. Firstly, qualitative methodology has the facility to explore and examine participants' statements and experiences in depth. It has been argued that quantitative approaches, in comparison, are seldom able to capture the subject's perspectives because they rely on more remote, inferential empirical methods and materials (Denzin & Lincoln, 2000, p. 10). Consequently, because this study sought

to explore participants' offence supportive statements, the qualitative approach was thought to be particularly suitable.

Secondly, it has been argued that sex offenders with a mental disorder are a small and distinct group and an understanding of their offending requires an overall view of the offence and the offender (Chiswick, 1983). This ideographic aspiration requires a qualitative investigation, which concentrates on the meaning of an individual's actions, when viewed in their subjective context. As this study was concerned with identifying participants' offence supportive statements and implicit theories, a qualitative analysis of each participant's interview transcripts was felt to be the appropriate method to explore the material.

A further justification for using the qualitative approach is its documented use in previous studies examining implicit theories in child sexual offenders (e.g. Marziano et al., 2006; Saradjian & Nobus, 2003; Ward & Keenan, 1999). Furthermore, there are no existing studies examining implicit theories in mentally disordered child sexual offenders. Using a qualitative approach allowed for the exploration of this area about which little is known and where it was therefore difficult to propose a research hypothesis or predefine all of the questions that might need to be asked. Finally, as this study is exploratory in nature, presenting an opportunity to generate hypotheses for further testing, the drawbacks are less problematic than if this was intended as a definitive study.

Qualitative Interview

The qualitative interview is the main method of collecting data used in qualitative research and was used to gather data in this study. The semi-structured interview format used in this study lies between the structured and unstructured qualitative interview methods. It combines flexibility with structure, the structure being sufficiently flexible to permit predetermined questions to be covered in the order most suited to the interviewee, as well as to be explored further through probing questions, which are not scripted and arise out of the interview itself, or the conversation occurring around the predetermined questions (Sheppard, 2004).

Thus, it provides the researcher with the freedom and opportunity to explore topics further if deemed appropriate or necessary (e.g. if clarification was required). This furnishes the explanatory evidence that is an important element of qualitative research. Additionally, it allows the researcher to be responsive to relevant issues raised spontaneously by the interviewee (Mason, 2002).

Qualitative and Quantitative approaches to examining Cognition in Sexual Offenders

It is well documented in the literature that the influence of social desirability might affect the responses of child sexual offenders, where a need to present themselves in a good light rather than reveal their genuine opinions and attitudes is preferred (Stermac, Segal, & Gillis, 1990). This conceivably highlights the difficulty researchers encounter when dealing with this heterogeneous group of individuals. Research into child sexual offenders' cognitive distortions has tended to involve two main methods: (a) the analysis of child sexual offenders' offence supportive statements gained through interviews with the offender or review of their clinical notes; and (b) questionnaires, in which child sexual offenders are asked to rate their acceptance of offence supportive statements which are compared to non-child sexual offenders participants (e.g. The Abel and Becker Cognition Scale (ABCS; Abel et al., 1989). There are advantages and disadvantages to using both methods.

Qualitative analysis of child sexual offenders' offence supportive statements appears to be a popular method amongst researchers wishing to gain insight into these beliefs (e.g. Hartley, 1998; Marziano et al., 2006; Saradjian & Nobus, 2003; Ward & Keenan, 1999). The main drawback to using a qualitative approach is that this approach relies on offenders to provide honest and accurate accounts of their offending. Verbalised accounts may well reflect only socially learned reasons or socially desirable responses. However, it is argued that examining what is said might tell us more about what these individuals are doing with their words in terms of justifying and denying, rather than just explaining the cognitive structures that these words represent (Burn & Brown, 2006). Another limitation is that there is no reliable way of knowing whether the statements reflect actual cognitive motivations.

For example, it is difficult to ascertain whether statements reflect general offence supportive beliefs held by offenders or post offence self-esteem maintenance statements.

Questionnaires have been used to investigate and highlight the difference between child sexual offenders and non-child sexual offenders' beliefs. This body of research has small effect sizes (Cohen, 1992) in conflicting directions and has not been particularly useful for evaluating theory-based hypotheses regarding cognitions putatively associated with the aetiology and maintenance of child sexual abuse (Hanson & Morton-Bourgon, 2005; Ward, McCormack & Hudson, 1997). Although they are designed to measure cognitions regarding self, children and other adults, the validity of such measures has been questioned by many researchers (e.g. Horley, 2000; Ward et al., 1997). A mixture of findings has been reported from this research. Blumenthal, Gudjonsson and Burns (1999) argue that such scales are transparent and that a difficulty with this method is its reliance on self report honesty from offenders. As these measures often use a 5-point Likert rating scale, Blumenthal et al. (1999) argue this may result in offenders opting for a neutral reply in preference to agreeing or disagreeing with the statements. Further, Quayle, Holland, Linehan and Taylor (2000) argue that a reliance on self-rating scales might serve to distance the offender from their own actions, thus focusing on the content of relative cognitions rather than investigating the processes that underlie the initiation, maintenance, and justification of sexual offending. Ward et al. (1998) argue these scales are a crude measure of deviant beliefs and attitudes that rely on the evidence of fairly static thoughts rather than investigating an individual's discursive strategy in a particular situation.

The measures are generally restricted to consciously accessible thoughts, thus assuming that child sexual offenders are fully able to access and report their offence supportive beliefs (Gannon et al., 2007). However, this is inconsistent with Ward's (2000) implicit theory hypothesis which suggests offence supportive beliefs are implicit and not thought to be consciously accessible. Thus despite the strengths of many self-report measures, they do not allow for adequate testing of

hypotheses regarding the aetiology and maintenance of child sexual offending (Mihailides et al., 2004).

Rationale for the Qualitative Interview Approach

Firstly, the method of qualitative interview produces detailed contextual information allowing for the participants' perspectives to prevail over the researcher's agenda and to be located within the context of their personal history and experience, as well as describing how they relate to the research issue (Sheppard, 2004). Consequently, this method enabled rich data and the offender's own personal detailed explanation of his offending to be gained. Secondly, as previously mentioned, implicit theories in mentally disordered offenders have not yet been explored. The qualitative interview allowed for the exploration of this area about which relatively little is known and the focus on the participants' views and experiences permitted issues/topics that the researcher may never have considered or deemed important to emerge.

Ward (2000) argues that offence supportive beliefs are not always consciously accessible to the offender. A qualitative interview approach is proposed to overcome the difficulty as the recounting of the offence may act as a prime for eliciting offence supportive beliefs. The artificial context of questionnaires does not provide this priming (Gannon & Polaschek, 2006). Furthermore, it has been proposed that child sexual offenders may be unconsciously providing information about their beliefs when recounting their offences but they may be unable to consciously access the same information when completing a questionnaire (Gannon et al., 2007).

Finally, as the research study involved exploring participants' sexual offending against children, the qualitative interview was particularly suited for exploring these sensitive issues and complex behaviours at a detailed level (Patton, 2002). The informal atmosphere of the interview afforded the researcher ample time to develop trust and rapport with participants, as well as opportunities to reassure them of the confidentiality and anonymity agreements, and reinforce the importance and

relevance of their views. Such factors can help participants to feel more engaged in the process, relaxed about participating, and therefore willing to open up and discuss their views at length (Silverman, 2000). This was particularly important given the literature on child sexual offenders and impression management (e.g. Hayashino, Wurtele & Klebe, 1995).

Content Analysis

Content analysis was the method of qualitative analysis used in this study. Content analysis is a research technique for making replicable and valid inferences from texts to the contexts of their use (Krippendorff, 2004). It is used to determine the presence of certain words, concepts, themes, phrases, characters, or sentences within texts or sets of texts and to quantify this presence in an objective manner. The drawing of inferences from the data is seen as the centerpiece of the content analysis technique (Neuendorf, 2002).

Conceptual Foundation

Krippendorff (2004) states that recognising meaning is the main reason that researchers engage in content analysis as opposed to some other kind of investigative method. He proposes that content analysts must recognise that all texts are produced and read by others and are expected to be significant to them, not just to the analyst. They cannot remain stuck in analysing the physicality of text but must look outside this and examine how various individuals use various texts. Krippendorff (2004) proposes six features of texts that are relevant to the definition of content analysis. Firstly, texts have no objective qualities. They arise in the process of someone engaging with them conceptually and their meanings do not exist inherent in them but are brought to it by someone. This leads onto the second point that texts do not have a single meaning that is found in it but that they have multiple perspectives. Thirdly, this meaning invoked in texts does not have to be shared. Demanding analysts reach a common ground would restrict the empirical domain of content analysis to the manifest aspects of communication or to a small sample of people who all view the world in a similar way (Bauer, 2002).

Krippendorff (2004) proposes the fourth feature of content analysis is that meanings of text speak to something other than the given texts and content analysts must look outside the physicality of texts and to its meaning as a whole. Krippendorff (2004) also proposes that texts have meanings relative to particular contexts, discourses or purposes. However, the differences in interpretations do not preclude the possibility of agreement within particular contexts, and once a content analyst has chosen the context within which to make sense of the text, the diversity of interpretations can be reduced. A context serves as the conceptual justification for reasonable interpretations, including the results of the content analysis. Finally Krippendorff (2004) states that the nature of a text demands that the content analyst draws specific inferences from a body of texts to their chosen context.

Content analysis thus seeks to 'reduce' the complicated mass of individualized data into themes common to much of the group (Weber, 1990). In content analysis, the researcher begins with a preconceived theory or proposition in mind. Once a particular context for a text has been chosen and clearly understood, certain kinds of questions become answerable and others make no sense. A judgment is made about key themes that emerge from the data, which are then written about as common characteristics in that particular group. The participants' open-ended talk is then coded into these closed categories, which summarize and systematize the data itself.

Content analysis is often considered to be a quantitative method, as the purpose is to turn complex material into a set of numbers within a relatively small set of categories. However, content analysis lies between the quantitative and qualitative divide, embodying the qualitative features of interpretation and close reading of texts, and then turning these features into quantitative data (Neuendorf, 2002). As a technique content analysis relies on several specialized procedures for handling texts, including coding, reducing data to manageable representations, abductively inferring contextual phenomena, and narrating the answer to the research question.

In undertaking a content analysis, the researcher has influence in what their analysis reveals (Krippendorff, 2004). For example, analysts often presuppose

certain contexts based on their own disciplinary commitments and hold particular theories concerning how texts are to be handled. While explicit terms or statements are easy to identify, coding for implicit terms and deciding their level of implication is complicated by the need to base judgments on a somewhat subjective system. To attempt to limit this subjectivity, as well as to limit problems of reliability and validity, coding such implicit terms usually involves the use of either a specialized coding system, as well as inter-rater reliability (discussed in more depth later in the paper). Such methods help in reducing subjectivity and the risk of very different findings been yielded from the same body of texts when examined by different analysts. When inconsistencies are located, analysts can present and discuss their evidence supporting their codings to reach an agreement. For a content analysis to be replicable, the analyst must explicate the context that guides their inferences. Without such explicitness, anything would go (Neuendorf, 2002).

Advantages

Content analysis is a research tool used to determine the presence of certain words or concepts within texts. The aim of this study was to identify cognitive distortions associated with Ward and Keenan's (1999) pre-existing implicit theories, as well as evidence suggestive of new themes. Consequently, content analysis was suitable given its obvious strength in determining the presence of preconceived themes and new data. Content analysis can transform qualitative material into numbers (Weber, 1990). This allowed the researcher to strengthen claims and add to the reliability of the findings. A final strength is that through the process of carrying out a content analysis (i.e. designing a coding frame and conducting the analysis), the researcher gained an in-depth knowledge of the material, facilitating the identification Ward and Keenan's (1999) proposed child sexual offenders' implicit theories, as well as evidence to suggest the presence of any new implicit theories. Transforming into new numbers also allows for broader, future research as questionnaires for example can be developed based on these themes.

Disadvantages

An important weakness of using content analysis is that it is not helpful in understanding why an individual would say what they did (Neale, 2009). Thus, in this study it does not further our understanding of the function of offenders' statements and whether they are precursors to offending or serve as post offence self-esteem maintenance strategies. Other research methods would need to be used to uncover these motivations behind the material, or pre-existing theory and evidence to hypothesise about them. Another limitation is that content analysis only provides information about what is contained within the material of interest (Neale, 2009). If biases exist in the material, and are not considered by the researcher, false or incomplete conclusions may be drawn. This is particularly relevant in light of the evidence suggesting child sexual offenders often respond in a socially desirable manner (e.g. Stermac et al., 1990). However, these limitations can be managed once the author is aware of them and undertakes the data analysis in light of them with due care/consideration.

Rationale for using Content Analysis

There were four main reasons for choosing this method of analysis. Firstly, content analysis methods are extremely useful when identifying and developing conceptual categories or themes because of their sensitivity to data patterns and generation of a rich source of relevant information (Willig, 2002). This is particularly relevant in light of the aims of this study which were to identify evidence supportive of Ward and Keenan's (1999) pre-existing child sexual offender implicit theories, as well as evidence of any new themes. Secondly, Ward et al. (1993) recommend analysing offenders' accounts of their sexual offending and argue this approach is an appropriate methodology, stating that "an offender's self-reported reasons for sexually assaulting.....reflect their own implicit theories and are therefore of considerable interest to theorists and therapists alike" (p.141). Thirdly, and as a follow on from the previous point, content analysis is a well recognised and documented approach for identifying implicit theories and has been used in several previous studies investigating implicit theories in child sexual offenders (e.g. Mann

& Hollin, 2007; Marziano et al., 2006; Polaschek & Gannon, 2004). Consequently, using this method of analysis allows for comparison with other studies undertaken within this framework. Furthermore, by incorporating the quantification of participants' cognitive distortions, content analysis gives a sense of the relative significance participants' attach to different cognitions, allowing for comparison between the different diagnostic groups.

Participants

The sample consisted of twelve male child sexual offenders with a mental disorder recruited from the specialist services from within one of the high secure hospitals in the UK. For admission to this special hospital, an individual must be subject to detention under the Mental Health Act 1983. Individuals were admitted under one of three classifications: mental illness, personality (psychopathic) disorder, or (severe) mental impairment. These categories were removed in 2007 following amendments to this act and replaced with the broad term 'mental disorder'. Thus, all patients now have a mental health classification of 'mental disorder'. Further admission criteria includes that patients are considered to pose a grave and immediate risk to others and that they require treatment in conditions of maximum security.

Inclusion and Exclusion criteria

A purposive sampling technique was used to identify participants. Participant selection was based on characteristics deemed theoretically meaningful to the study. Participants were selected for inclusion in the study on one of two grounds:

(1) If they had a clinical diagnosis of mental Illness (e.g. schizophrenia) and/or personality disorder (PD).

(2) If they had a documented history of a contact sexual offence against a child.

In the current study a child was considered to be anyone below the age of 16 years.

Participants were excluded from the study based on the following criteria:

(1) If their Responsible Clinician (RC) felt they could not provide informed consent

(2) If the participant refused consent to be interviewed/recorded

(3) If the participant was floridly psychotic impacting on their ability to give consent and/or to be interviewed

(4) If the participant had committed sexual offences against adult victims only

(5) If the participant had a diagnosis of learning disability

(6) If the participant did not speak English fluently.

Patients with special communication difficulties and/or who did not speak English were excluded due to the results of the study being solely reliant on interview data and the participants' own subjective descriptions of their offending.

Identification of potential participants

Using the study inclusion and exclusion criteria, a resident psychologist working within the hospital identified participants from the patient computer database system. This database system lists all patients in the directorate, their mental health classification, their location in the hospital and their offence type. As mentioned, according to the new Mental Health Act (2007) all participants have a mental health classification of Mental Disorder. Thus, to identify participants' clinical diagnosis, their case files were referred to by the resident psychologist. These files contain information regarding participants' life history, including their offending history, current and previous progress reports by all professional disciplines involved in their care, mental health review tribunal outcomes and official correspondence. Participants' clinical diagnosis was that recorded in their most

recent treatment care plan. Participants' case files were also referred to in instances where participants' offence details were not logged on the database.

Sample Size

24 child sexual offenders were identified as suitable to take part in the study. The number of participants who agreed to participate was 12. This number was the greatest number of participants that was expected to be recruited within the constraints of this specialised population and the study. Furthermore, this figure satisfies the sample size requirements for qualitative methodology using content analysis (e.g. Morse, Barratt, Mayan, Olson & Spiers, 2001). Among the 12 participants who were not included, five refused to participate in the study, one was denying his sexual offending, two were actively psychotic at the time of the study, and there were four participants whose RC did not feel they could provide informed consent to participate.

Sample Description

On the basis of clinical diagnosis, participants were classified into three groups: participants with a clinical diagnosis of major mental illness (MI; n = 5); participants with a diagnosis of personality disorder (PD; n = 5); and participants with a diagnosis of major mental illness and an additional personality disorder (MIPD; n = 2). The age range for the sample at the time of data collection was from 33 to 61 years (mean age = 45.3yrs; SD = 9.69yrs). All participants' IQ functioning was within the normal range.

Participants were classified as intrafamilial offenders if all of their known offending was against a member of their own family, including step children, or involved children within a current/previous relationship (n = 3). Participants were categorised as extrafamilial offenders if they had offended against children with whom they had no biological or legal relationship (8). Participants who offended against children both within and outside their family were classified as extrafamilial (n = 1).

The age range of victims, who were predominantly female, was from 18 months to 15 years. At the time of the study, participants had either completed a cognitive behavioural sexual offender treatment programme (SOTP) (n = 7), or were undergoing treatment (n = 5).

Measures

Semi-structured Interview

A semi-structured interview schedule, devised by Ward, Louden, Hudson and Marshall (1995), was utilised in this study to develop a descriptive account of each participant's sexual offending and to explore their implicit theories (See Appendix A). The main advantages of using this schedule were: (1) it was designed by researchers for use in previous research investigating child sexual offenders' implicit theories (e.g. Marziano et al., 2006). This ensured it had a clear purpose and allowed for uniformity of topics across the entire sample of participants, permitting collation and analysis of data from questions asked; (2) as the interview questions were developed from previous research on child sexual offenders, it ensured the researcher's agenda did not dominate; and (3) it allowed the researcher flexibility to ask the set questions in the order most responsive to the participants' responses, as well as for certain answers to be explored further through probing questions, which are not always scripted but sometimes arose out of the participants' disclosures.

Description of Interview Schedule

Each interview consisted of an initial framing statement to open the interview and orient the participant by asking him to think back to his life at the time of his offence, and to take the perspective of the person he was at the time of the offending. By anchoring the individual in this manner, it was hoped that this would further facilitate an open and honest discussion in regard to the relevant offence details.

Questions related to participants' level of daily functioning at the time of their offence (e.g. typical questions about cognitive/affective/behavioural experiences). More specific questions were derived from themes suggested by the five implicit theories. Themes included their beliefs regarding their victim's sexual knowledge; how they viewed the abusive relationship; their perception of child/adult relationships; their view of the impact of stressors at the time of the offending; their perception of harm committed; and the level of control they exercised during their offending. Where appropriate, questions were also asked about their previous offences. Offenders were also asked other prompt questions on the basis of their answers to these questions.

Broad, open-ended questions were used to gather this information. General prompting questions were utilized at three points throughout the interview. These points reflected pre-offence, offence, and post-offence stages of the offending chain. The questions encouraged the participants to talk specifically about the details of their offence chain, and to relate their ideas, values, desires, and beliefs regarding the sexual offending of children. Pre-offence material consisted of personal, social, familial, interpersonal and vocational matters. Material for the offence stage of the interview was ascertained by asking participants to "talk through" the day of their offence from the time they woke up in the morning to the time directly after the offence. Post-offence material related to how they viewed their behaviour and victim in the days and weeks following their offence, and if they committed another offence, what they were experiencing at that time.

Audio Recording/Transcribing Equipment

The emphasis on depth, nuance and the participants' own language as a way of understanding meaning implied that interview data needed to be captured in its natural form. Thus, tape recording was carried out to ensure an accurate verbatim record of the interview. Additionally this allowed the research her to listen to the participant and probe in-depth. Audio recording is also a more neutral and less intrusive way of recording the interview than for example, visual recording methods.

A microcassette recorder was used to record all of the interviews. A Dictaphone was used to transcribe the semi-structured interviews. All participants provided consent for their interviews to be recorded (See Appendix B).

Procedure

Step 1: Participant Identification

Using the study inclusion and exclusion criteria, a resident psychologist working within the hospital identified potential participants from the patient database systems. Letters were then sent to the appropriate RCs informing them of the study and requesting permission for patients under their care who were identified as suitable to participate to be invited to participate. All RCs were given an information sheet outlining the nature of the study (See Appendix C). They were also provided with consent forms to sign for each identified potential participant (See Appendix D). If RC's agreed, they signed the consent forms and returned them to the researcher via the hospital post.

Step 2: Participant Recruitment

Identified participants were asked whether they were interested in participating in the research. This usually occurred in participants' clinical ward rounds with the multidisciplinary team present. They were provided with written information about the study to read. This included an Information Sheet (See Appendix E) and two Consent forms – one to consent to participation and one to consent to be audio-recorded (See Appendices F and B). Those who agreed to participate were asked to sign the consent forms and return them to the researcher via the hospital post. Patients who had any questions regarding the research, or who needed any terms explained to them, were informed that they had the option of requesting a meeting with the researcher to help provide clarity to their questions and to allow them to decide whether they wanted to participate. This was done by the participant asking the ward staff to contact the researcher on the number provided on the information sheet and arranging a time to meet with the patient.

Step 3: Completion of Semi-Structured Interview

Once a participant agreed to participate, the researcher arranged with ward staff a convenient time to carry out the interview with the participant. This time did not conflict with any scheduled weekly activities participants had. All interviews were conducted individually by the researcher in a private room on each participant's ward. Interview sessions generally ranged between 50 – 70 minutes in duration. Issues of confidentiality were reiterated prior to commencing interviews. Once interviews were completed, they were transcribed verbatim into written text by the researcher and a hospital administrative secretary. Participants' names and any other identifiable data were removed. Transcripts were coded prior to analysis to secure anonymity; a number was used to identify each transcript. Information relating to this coding system was only known to the researcher throughout the study. All data is being stored for up to 5 years in a securely locked filing cabinet in one of the specialist services. Only the researcher and her supervisor have access to this.

Ethical Approval and Consent

Firstly, ethical approval was sought from NHS Research Ethics Committee (NRES) and the Trust's participating Research and Development Committee (R&D). The University of Lincoln's Ethic committee also approved all procedures and materials for this study. The study was conducted according to the Code of Ethics of the British Psychological Society.

The in-depth unstructured nature of qualitative research and the fact that it raises issues that are not always anticipated mean that ethical considerations have a particular resonance in qualitative research studies.

- *Informed consent*

Participants' informed consent to participate was sought prior to them being interviewed. This meant debriefing all participants about the rationale for the study. Each participant was provided with a written information sheet outlining (a)

information about the purpose of the study, (b) what their participation in the research will require of them – the topic of investigation, how much time is required etc, (c) the need to check their case notes, (d) how the data will be used, and (e) their right as a participant (See Appendix E).

Informed consent was based on the understanding that their participation was voluntary. Particular emphasis was given to this so as to prevent patients feeling obliged or pressurised into taking part in the study. Those who gave consent were informed that they are not under any obligation to take part in the study and they would not benefit personally from their participation. Due to the sensitive nature of the conversations, participants' right to refuse to answer questions and terminate the interview at any time was emphasised. Participants were assured that withdrawing from the study would not result in any negative consequences for their treatment or legal conditions.

- *Anonymity and confidentiality*

In order to minimise response distortion, the proposed conditions for anonymity and confidentiality were given particular thought and made clear to participants. Anonymity means the identity of participants not being known outside the research team. Due to the fact that participation was arranged through RC's and ward staff, absolute guarantees of anonymity could not be given to participants. This was discussed with them.

Confidentiality means avoiding the attribution of comments in write-ups to identified participants. Participants were informed that extracts from their interviews would be quoted in the write up of this study but informed that the quotations would not be directly attributed or linked to them individually.

Regarding the recording of interviews, participants were briefed about the rationale for this and informed that no one other than the researcher and an administrative secretary woulsd have access to the tapes. They were asked to sign an audio consent form prior to commencing the interview. Regarding the storage of interview

data, tapes and transcripts were not labelled in ways which could compromise anonymity and identifying information was stored separately from data.

- *Protecting participants from harm*

Given the sensitive nature of the research topic, consideration was given to ways in which taking part may be harmful to participants and plans were developed to reduce these risks. The main identified risk for participants was that they may experience distress from discussing their sexual offending. Participants were given a clear understanding of the study aims before being asked to participate. Prior to each interview the researcher restated the aims of the study and reaffirmed confidentiality and requirements of participation to ensure the terms were agreed.

The researcher was alert to signs of discomfort/anxiety. In the event of a participant becoming distressed/anxious, or if the researcher thought that completing the interview was having a negative effect on a participant's mental health, their willingness to continue was checked and the option of stopping the interview was given to them.

After completing the interview, all participants were debriefed by the researcher. They were asked if the task had brought back any memories or feelings they were finding difficult to cope with. If this was the case, the researcher afforded the participant time to discuss these anxieties. Care was taken to ensure the researcher's role was not confused with that of counsellor/adviser. If participants indicated a need for support after the interview, they were encouraged to speak with ward staff or the ward psychologist. In the event that a participant refused to do this, the researcher, adhering to the hospital security policy, explained to the participant that she would have to inform ward staff about the session without unnecessary disclosure (e.g. disclose that the participant experienced distress having spoken about a sensitive topic and to be available for support if required).

No other risks were identified. Participation did not lead to any changes in participants' care plan or treatment. Completion of interview took up to a maximum of 90 minutes of their time but the researcher arranged to meet with them at a time

convenient for them so that their participation in the study did not interfere with their other activities.

There were no identified personal benefits for participants other than that to their self-esteem and feelings of worth through helping the researcher, professionals and other patients in the future, as well as advancing care and treatment in the NHS.

- *Protecting researcher from harm*

Arrangements were made at the beginning of the study to minimise risk of harm to the researcher. The researcher completed an induction to the hospital and adhered to security requirements throughout the process (e.g. carrying a secure alarm into the interview room, informing staff of her whereabouts, enquiring about participants' mood prior to interviewing). In any instance where the researcher felt to be at risk, interviews were to be terminated. Through the use of clinical supervision, opportunities for debriefing and support were available to the researcher in the case where difficult situations were encountered.

Plan of Analysis

Analysis is a continuous and iterative process in content analysis, with two key stages characterising its course. The first required managing the data. The second stage required making sense of the data through descriptive or explanatory accounts.

Stage 1: Data Management

The first stage of the analysis involved transcribing the interviews. This was done by the researcher and an administrative secretary working within the hospital. Once an interview was completed and transcribed, it was read a number of times to gain a general sense of participants' accounts prior to and during the analysis of data.

Stage 2: Making sense of the Data

The next stage of the analysis involved subjecting the transcripts to content analysis and identifying the presence of implicit theories by coding and summarising the data.

Coding

Coding is the means by which meaning will be assigned to the qualitative data and emergent themes identified from the data. In this study, the coding frame (See Appendix G) was designed with an understanding of the theoretical background to the research question in order to make sense of the data. The five implicit theories identified in the literature by Ward and Keenan (1999) - children as sexual beings, nature of harm, dangerous world, and entitlement – were used as a common system of thematic categories which were applied across the whole data set and this template was used as a means of searching for and identifying the presence of these themes. The researcher (KM) collated examples of cognitive distortions identified in the literature as being suggestive of these implicit theories (e.g. Ward & Keenan, 1999) and grouped them accordingly under the relevant implicit theories. This coding template helped to familiarise and focus both the researcher and the second and third authors, who acted as independent raters, on the types of statements that were of interest and meaningful to the question when examining each participants' transcript. This approach offered a systematic overview of the scope of the data and aids finding themes which do not appear in an orderly way as well as helping to manage the data so as to make comparisons and connections.

Implicit Theory Identification

The researcher divided the interview transcripts into three groups based on participants' clinical diagnoses: group one consisted of child sexual offenders with a diagnosis of mental illness (MI), group two consisted of child sexual offenders with a diagnosis of personality disorder (PD), and group three consisted of child sexual offenders with a dual diagnosis of mental illness and personality disorder (MIPD). Starting with group one, the researcher individually examined each participant's

transcript using the Ward and Keenan's (1999) five implicit theories as coding schemes and picked out examples of statements suggestive of these from each transcript. Where statements were found to suggest the possible presence of an implicit theory, the researcher labeled them with the initials of the appropriate implicit theory. For example, statements suggestive of an entitlement implicit theory were labeled 'E'. The researcher also checked participants' transcripts for any statements/phrases which did not appear to fit into the predetermined implicit theory categories, but which appeared to be functionally related to participants' offence. Where such statements were found, the researcher labeled it 'miscellaneous category' so that it could be later examined to see if it provided the conceptual material for the formation of new implicit theories. Once a transcript had been coded, it was re-examined by the researcher to see if there were any other implicit theories or miscellaneous data of significance that had been undetected. The researcher then entered each participant's identified implicit theories, miscellaneous categories and supporting statements into their individual coding sheets (Appendix H). This process was repeated on the transcripts obtained from participants in group two (PD) and group three (MIPD). When all participants' transcripts had been coded, the researcher listed the type of implicit theories identified for each patient diagnostic group and calculated the frequency of each implicit theory by counting the number of participants it was identified in across the participant group.

The second and third author independently carried out this coding process on all participants' transcripts as part of the ongoing checking process in order to sustain high levels of reliability and accuracy (see 'Generating Reliability Data' next section).

Evaluation of the Research

Alongside the growth in popularity of qualitative research designs, concerns have been raised over the rigor of qualitative research and its susceptibility to bias (Seale, 1999). In evaluating a study, judgments are made about the validity, reliability and credibility of the data (Strauss and Corbin, 1998). Such issues are

appropriate whether one's use of quantitative or qualitative data. Consequently, throughout the content analysis in this study the researcher paid attention to issues of reliability and validity.

Reliability

To stand on indisputable ground, Krippedorff (2004) proposes content analysts need two things. First, they must be confident that their data has been generated with all conceivable precautions in place against known distortions and biases, intentional or accidental. Second, they need their data to mean the same thing for everyone who reads it. Reliability grounds this confidence empirically. Data is thought to be reliable when it remains constant throughout variations in the measuring process by responding to the same phenomena in the same way regardless of the circumstances of its implementation (Krippedorff, 2004). If the results of reliability testing are compelling, this allows researchers to move forward with the analysis of their data. If not, doubts as to what the data means and its worth prevail, and its analysis is hard to justify.

Content analysis must be reproducible (Krippendorff, 2004). To check on this possibility, analysts must generate reliability data that are obtained under test-test conditions and account not only for individual instabilities but also for disagreements among observers, coders or analysts. To help ensure the reliability of qualitative research, a content analysis using observed agreement as a measure of reproducibility must meet the following requirements (Krippendorff, 2004). Firstly, there is the need to carry out internal checks on the quality of the data and its interpretations. Three or more observers working independently of one another should be employed. This yields reliability data whose reliability can be measured. Second, discrepancies in their data are reconciled by relying on a formal decision rule (e.g. majority judgements) or by reaching consensus in post-coding deliberations.

Consequently, the researcher in this study had to ensure that the findings were both stable and reproducible. For the findings to be stable, the researcher had to be

able to code the same data into the coding frame more than once and obtain the same results. For the findings to be replicable, the independent raters had to code the material independently using the same coding frame and obtain the same results. As Weber (1990) states, "high reproducibility is a minimum standard for content analysis. This is because stability measures the consistency of the individual coder's private understandings, whereas reproducibility measures the consistency of shared understanding (or meaning) held by two or more coders" (p.17).

Generating Reliability Data

In the current study, inter-reliability checks were utilized. The second and third author (the researcher's tutor and clinical supervisor), who played no role in the interview process or implicit theory coding, acted as independent raters and examined the reliability of the researcher's implicit theory identification. The first task involved them checking the reliability of the researcher's identification of implicit theories and miscellaneous categories for each participant, while the second task involved them checking the reliability of the researcher's allocation of statements to one of the five implicit theories and miscellaneous category. Similar to how the researcher analysed and coded participants' transcripts, the two independent raters, with no knowledge of the researcher's coding, examined clean copies of all participants' interview transcripts to identify Ward and Keenan's (1999) five implicit theories and any miscellaneous categories. When they had completed coding all the transcripts, they entered the identified implicit theories, miscellaneous categories and supporting statements for each participant into their individual coding sheet.

After independent ratings were complete, the researcher and two independent raters' met to compare the results of their coding and check the reliability of their implicit theory identification and allocation of statements to the implicit theory and miscellaneous categories. To check the reliability of their identification of implicit theories, each rater listed the theories they identified for each participant as recorded on the participant's coding sheet. To check the reliability of their allocation

of supportive statements to the implicit theory and miscellaneous categories, the main author listed all the statements she identified as being supportive of each implicit theory identified for each participant and the other raters agreed or disagreed with this coding where appropriate. Where disagreements occurred, statements were categorised into one of the implicit theories by raters reaching a consensus in post-coding deliberations.

Validity

A measuring instrument is said to be valid if it measures what its user claims it measures. Thus a content analysis can be seen as valid if the inferences drawn from the available texts withstand the test of independently available evidence, of new observations, of competing theories or interpretations, or of being able to inform successful actions (Krippendorff, 2004). Qualitative researchers with their in-depth access to single cases have to overcome the problem of convincing their audience that their findings are genuinely based on critical investigation of all their data and do not depend on a few well chosen examples. This is known as the problem of anecdotalism. Miles and Huberman (1994) notes transcripts are rarely available, which would allow the reader to formulate his or her own hunches about the perspective of the people studied. Lincoln and Guba (1985) are also in clear consensus that qualitative research needs very clear descriptions, both of methods used and the findings, to aid checks on validity by others.

In the current study, the research process and method was explained in depth, and the use of direct quotations from participants was an extremely powerful way of bringing the findings alive and reinforcing their validity. Such transparency as Lincoln and Guba (1985) advocate, allow the reader to verify for themselves that conclusions reached by the researcher hold ‘validity’ and to allow others to consider their ‘transferability’ to other settings. Additionally, triangulation through multiple analysis was utilised. This involved using different raters to compare and check the identification of implicit theories and their supportive cognitive distortions.

Simple counting techniques, theoretically derived from and ideally based on participants' own categories, can offer a means to survey the whole body of data ordinarily lost in intensive qualitative research. Consequently, in this study, the use of tabulations was used. As Kirk and Miller (1985) state, "qualitative research implies a commitment to field activities, it does not imply a commitment to innumeracy" (p.10). A coding form was constructed which enabled the researcher to collate the frequency of participants' implicit theories. The aim was to demonstrate that the qualitative analysis was representative of the data as a whole. Using the sets of data, a more convincing argument regarding the validity of findings could be made.

Extended Results

This study was an exploratory investigation of implicit theories in child sexual offenders with a mental disorder. As such, no specific hypotheses were made although two main questions guided the investigation.

1. Will evidence of Ward and Keenan's (1999) five hypothesised child sexual offenders implicit theories, or new implicit theories, be found in a group of high secure child sexual offenders with a diagnosis of mental disorder?

2. Will diagnosis impact upon the type of implicit theories held by these offenders? For example, will child sexual offenders with a mental illness provide support for different or similar implicit theories to those suggested by child sexual offenders with a personality disorder?

These questions will now be individually addressed. Findings will be reported and participants' quotations will be provided. Providing direct quotations from transcripts in qualitative research helps to increase the validity of the findings and the researcher's conclusions. This allows the reader to get a feel for the interview material and to form his/her own opinion about the understanding the researcher has come to.

Question 1: Will evidence of Ward and Keenan's (1999) five hypothesised child sexual offenders' implicit theories, or additional implicit theories, be found in a group of high secure child sexual offenders with a mental disorder?

Krippendorff (2004) states that to help ensure the reliability of qualitative research, a content analysis using observed agreement as a measure of reproducibility should (1) have three or more observers working independently of one another to carry out internal checks on the quality of the data and its interpretations, and (2) should rely on a formal decision rule (e.g. majority judgements) or by reaching consensus in post-coding deliberations, to reconcile discrepancies in their data.

In the current study, three raters working individually of one another analysed participants' interview transcripts using Ward and Keenan's (1999) five implicit theories as coding categories. These are *Children as Sexual Beings, Nature of Harm, Uncontrollability, Dangerous World* and *Entitlement*. Evidence for these five implicit theories was found by all individual raters in the sample of child sexual offenders with a mental disorder. When raters met up to compare the results of their coding, they listed the implicit theories they identified for each participant as recorded in participants' individual coding sheets. Results indicated that they had 100% agreement on the identification of implicit theories categories for each participant. Raters also checked the reliability of their allocation of statements to the particular implicit theories. Following discussion, raters agreed on 100% of the statements classified into the implicit theories except for two statements related to the Dangerous World implicit theory. However, the resulting classification did not differ more than these two statements and this was judged to be insignificant. The decision of how to classify these two statements was made by raters reaching a consensus in post-coding deliberations.

Each of the implicit theories will now be discussed separately. The prevalence of each implicit theory will be reported, as well as direct quotations from participants' interviews. Results from participants with a mental illness and/or personality

disorder are discussed as a whole. A separate analysis of their implicit theories can be found later in this section (see Question 2).

Children as Sexual Beings

Evidence of cognitive distortions associated with this implicit theory was found in half the participants (50%). The content of this implicit theory was found to be reflected in different ways by participants, but the underlying theme was the offender's belief that children are sexual beings who want and enjoy sex, as well as being capable of deciding for themselves to engage in sexual activity with an adult.

Two participants described the child in their offence as someone who was promiscuous and sexually experienced. An example of this includes:

"*She had a bit of a reputation that she was always sleeping with lads. It was on a plate with her, it was dead easy and you didn't really have to try*"

One participant commented on how the child not only acted older than her years but she also "*looked a lot older*". On reflection of his offence with an awareness of the child's correct age, this man maintained his belief that all young people, particularly between the ages of 12 and 16 want sex. He explained how it is important for a child to lose their virginity and he saw this as being part of a child's development. This necessity and acceptability for young children to become sexually experienced was the main theme in his transcript.

"When you're young, in your teens or your early 20s, you know you've got to have it, regardless of whether you enjoy it or not, you've got to do it. Its part of being young"

The other participant who viewed his victim as sexually experienced explained:

"It was just the way she was, she was a very pretty girl and she was well educated in that department"

Seeing the child in this way, as someone who was sexually active and wanting sex, he described having sexual activity with the child as he was continuously presented

with the opportunity to accept the child's invitations to have sex. He described how he saw it as a 'game' he was "teased" into.

"To be honest with you, I was always thinking to myself, if this is how its going to be, you know, teasing, I call it teasing, teasing me the whole time, I said 'fine by me, Ill just play along"

He felt his victim was responsible for the sexual activity between them and described it occurred

"*because of the way she was acting, she'd like walk up to me and blow kisses at me".*

Seeing the child through this sexualized lens, this man reported how he treated the child as if an adult partner. Other participants also described their relationship with the child in their offence as if the child were an adult, particularly those men who abuse of the child was an ongoing behaviour. Relationships of varying levels of intimacy were developed by participants who misinterpreted the child's responses to these relationships. Participants frequently appeared to justify their sexual abuse by redefining the abuse as an expression of their love or as a loving consensual mutual relationship between them and the child rather than as an intrusive abuse of a child. As one participant described,

"*I actually thought to myself we could get together. And have a proper affair, when she was older, and that's a lot better as well. And we could settle down, which she agreed to as well so we had that kind of bond"*

Some of the children were made to feel at least partially responsible for their abuse. One participant reported how he turned the child in his offence into the gatekeeper of her own victimization, by saying that he would only do the things she wanted or allowed and would only engage in sex with the child after asking her *"do you want to do it?".*

As these examples demonstrate, participants holding this implicit theory reported perceiving the child as not only someone who was capable of deciding whether to

have sex with an adult or not, but also as encouraging the sexually abusive experience. It was common for these men to report that the child had encouraged the sexual contact. They commonly perceived the child's behaviours as sexual, as well as the child's responses to the sexual abuse. Participants gave different reasons and evidence to support this. For example, one participant described how sexual his victim could be and how he knew by her behaviour that she wanted the sexual contact with him. He described her as being:

"*all the sexual side……I mean sometimes I couldn't keep up with her"*

Another participant stated the child in his offence came into the kitchen "*with her pants off and so I knew what she wanted, you know, call it that loving touch*". And yet another participant claimed the child wanted it as "*she didn't refuse*".

As well as reporting that the children in their offences wanted the sexual activity, participants also reported that they felt the children enjoyed it. Again, they attributed this to the child's behaviour during the offence. One participant described how his victim was "*moving her legs"* which he interpreted as *"she was enjoying it. And she was gurgling*". Another participant interpreted the child's silence as meaning she enjoyed it

"*I felt that she enjoyed what we were doing, she didn't complain. We kept it to ourselves she didn't tell her mum".*

These statements demonstrate how participants holding the 'Children as Sexual Beings' implicit theory commonly reported perceiving the child in their offences to be sexually aware, available, and in some cases, sexually encouraging. They described their relationship as loving and consensual rather than abusive. This idea of their offending as non-abusive acts is suggestive of the 'Nature of Harm' implicit theory.

Nature of Harm

Evidence for this implicit theory was found in eight (66.6%) of the participants. Ward and Keenan (1999) describe two main variations of this implicit theory and both were evident in this study.

In the first variant, child abusers conceptualise harm as being on a continuum with behaviours ranging from minor to major in terms of the impact they have on an individual. Participants often gave examples of other more serious behaviours which they did not inflict upon the child, which in comparison to these, participants reported that they did not feel that they had harmed the victim. One participant explained how he did not feel that having sexual intercourse with the child in his offence was abusive as he did not cause physical hurt or mental abuse.

"*I really didn't want to hurt them, I didn't think I was. For me to hurt someone it would have to be either physically or mentally. Sex was just a word to me*"

Another participant also explained that because he did not use any source of threats or physical violence against his victim to engage in or during the sexual abuse, damage to his victim, if any, was minimal. He felt that only direct and explicit forms of violence and aggression were harmful.

"*I definitely didn't use any sort of violence or any threats against them. I didn't say if you say something about what's happened I'll do*"

Another common theme was for participants to conceptualise different sexual behaviours in terms of harm. For example, some participants reported how kissing and touching were non-intrusive acts, whereas sexual penetration of the child was considered to be abusive. In the absence of sexual penetration, most participants reported that their behaviours were not harmful and did not constitute abuse. Examples illustrating this include:

"*I was just messing about, it weren't anything serious, there was no intercourse or anything like that, no penetration, just touching and things like that".*

"to me when I was with children I wasn't abusing them, I was just loving them, you know stroking them etc etc".

When asked how serious he felt his offence was, another participant replied *"well nothing major as I didn't have intercourse with him".* Another participant compared his sexual abusive behaviours to those he endured as a child. He stated that because he suffered more extreme forms of sexual abuse, what he was doing to his victims was not serious.

"I was abused as a kid but I heard a lot more happened to me than what I'd done to those kids"

The second variant of this theory concerns the belief that sex is a harmless act which is unlikely to harm the child. When asked to describe what he was thinking about his victims at the time of his offence, one participant stated

"*that they're not frightened; they're enjoying this; it's educational for them*".

Two participants reframed their sexual offending as a game between them and the child. One of these participants explained it was "*just good fun*". For the other participant, he described his offending as a "*game*" which allowed him to and maintained his sexual offending. Another participant stated that he had difficulty understanding why his sexual offending behaviours were wrong as he *"didn't see it as hurt, just me loving somebody*".

Participants commonly reported their behaviours as harmless based on their interpretations of their victim's behaviours. Common examples demonstrating this include:

"They weren't showing any sign physically"

"She didn't put up a struggle; she weren't kicking or anything like that"

"She never did or said anything to make me feel I had harmed her"

Uncontrollability

Ward and Keenan (1999) propose that child sexual offenders holding this implicit theory see their sexual abusive behaviours as occurring because of both internal and external factors outside of their control. Evidence for this implicit theory was found in ten participants (71.66%). Participants explained their sexual offending as being unavoidable and uncontrollable due to a range of different factors. These are now described.

Personal experience of childhood abuse and poor role models

Nine participants described how they had been abused as a child and stated that they felt this was a causal factor in their offending. They described earlier childhood environments characterized by physical, emotional and sexual abuse, where they were victims of abuse or witnesses to abuse. They reported lacking appropriate role models to demonstrate positive and prosocial behaviours and attitudes, and felt their upbringing had shaped their behaviour and led them to offend in a sexual way. Participants described different ways in which they felt their early abuse influenced their sexual offending of others. For some participants, they stated that their own experience of sexual abuse normalised sexual abusive behaviours for them. They stated that they were unaware such behaviours were considered unacceptable by society and how they felt it was the norm. An example illustrating this includes:

"I was abused as a kid. I felt that it was the norm to have sex with children and that's probably at that time what made me drive, go forward"

Another participant described how he witnessed his father physically and sexually abuse his mother and explained that he began masturbating to these sexually aggressive images and this association strengthened as time progressed and he developed into a man.

"Seeing things like that I thought it was what happened. Triggered off things in my head and then it just went. Masturbated to those fantasies, I became a man too quick."

Another participant blamed the lack of parental guidance as the reason he sexually offended. He spoke about the lack of a positive role model throughout his childhood.

"I wouldn't know any different if no-one's ever told me but my Mom and Dad never told me nothing".

For other participants, their felt there sexual offending was a consequence of their built up aggression and anger over their experience of being abuse, which they felt unable to control. One participant described his offending as being "*driven by rage*".

Alcohol and Drugs

Three participants referred to alcohol and drugs as being influential in their offending. However, in all cases offenders described other factors as being more influential and directly responsible for their offending behaviours, for example, their sexual drive or their paranoia and suspiciousness of others. They described using alcohol and drugs to cope with their problems but that they acted as disinhibitors and a catalyst to their pre-existing paranoia and high sexual drive.

"It [paranoia] was getting worse. The crack was making it worse"

Participants did not feel they had any other options for coping than to use alcohol and drugs. Because they were under the influence of these at the time of their offending, they did not perceive themselves to be responsible or in full control of their behaviours.

"I started drinking heavily and then one day I committed a serious offence"

Sexual Thoughts and Urges

Participants commonly cited their high sexual drive as being responsible for their offending. One participant explained:

"*It was sort of like sex was on my brain all the time. I couldn't get rid of it*"

Participants described how they could not control these urges and the constant need to relieve themselves sexually drove them to commit their sexual offences. Examples include:

"I was out of control, that's why I was always offending in a sexual way. My urges would start happening and they'd get stronger. I could never stop it"

"It was very hard for me not to do it because as I saw it at that particular time, as I see it now, I went and sexually abused them, the urges were just too strong".

"*My mind was thinking with my penis and my penis was thinking with my mind and both were tied up together and it made my sex drive a bit high"*

One participant described how he tried to fight his urges before approaching the child in his offence but how it was "*was really hard to like force myself to stay in the chair*"

Participants' reported how their urges were constant and consistent, and their satisfaction was not maintained perpetuating further episodes of abuse to manage their urges.

Voices and Paranoia

Only two of the seven participants with a clinical diagnosis of mental illness made any reference to their mental illness as being influential in their sexual offending. In both cases, participants stated that they experienced persecutory voices. One participant felt there was a conspiracy against him and that people were going to harm him. He stated that he felt the child in his offence was in some way involved

because he ‘laughed’ at him. He stated that he his sexual offence was driven by a mixture of anger and paranoia and to seek revenge. Rather then seeing their mental illness as causing their paranoia and suspiciousness, both men explained that they felt it perpetuated their pre-existing longstanding paranoia and suspiciousness of others. One of these men explained:

“*I started to hear voices as well. I can’t control them [occurring] but I can control my response to them”*

Neither participant viewed their psychotic symptoms as being directly responsible for their offending and linked their paranoia to previous abusive childhood experiences which they felt made them perceive people as being untrustworthy. Their anger and paranoia of others which they perceived as being incontrollable have links with the ‘Dangerous World’ implicit theory.

Dangerous World

Evidence for this implicit theory was found in nine of the participants (75%). Ward and Keenan (1999) proposed two streams to this theory. Offenders holding the first stream are hypothesised to perceive the world and others, including children, as hostile and exploitive. They offend as a way of controlling and dominating others rather than themselves being the victim. Offenders holding the second variant are hypothesised to view adults are rejecting and hostile and to perceive children as being reliable and safe. Results of the current study indicate that it was more common for participants to articulate cognitive distortions associated with the second variant of this implicit theory and evidence for this variant was found in seven of the nine participants. Only two participants held the first variant of this theory and stated they felt angry at the world in which there was no-one whom they could trust.

“The worst thing was I couldn’t trust nobody”.

“I was bitter at the world, bitter to everybody”

One participant explained that consequent to his own childhood abuse, he had withdrawn from the world and did not want to let others get close to him as he feared further exploitation and betrayal. Instead he remained hyper vigilant to any perceived signs of harm from others. He stated that he sexually offended as he wanted to make "*an example*" out of the child and to show others that he was not to be "*fucked with*". This man denied any sexual interest in the child, describing it was purely for *"revenge*". He stated that raping the child was the only way that he could "*really hurt this kid, by breaking him down".* He described being sexually gratified from being in complete control of another human being.

"It was the fear, the humiliation and degradation that turned me on"

The other man who expressed cognitions supportive of this first variant stated that his sexual offending was also a way of seeking revenge on a society of people who he felt bullied him and treated him unfairly. He described not being able to cope with his intense feelings of anger and releasing them in the form of a sexual offence against a child. He stated that his offence was opportunistic and that the child was "*just there and I looked at her and I thought you know what you could get me a life sentence and I'm going to make sure I get a life sentence. And I sexually assaulted her. Touched her".* He also denied any sexual interest in the child, stating that he felt "*more angry than anything"* and *"disgusted"* by it. The sexual offending of both of these participants was part of a larger and more pervasive history of antisocial behaviours.

The other seven participants expressed cognitive distortions supportive of the second variant of the Dangerous World implicit theory. They reported viewing children as being the only source of safety and comfort in an otherwise hostile and rejecting world. They frequently described adults as threatening and dangerous and that being in their company evoked memories of early abuse and feelings of inadequacy, isolation, inferiority and fear. They stated how they struggled to initiate, engage in and maintain adult interactions. Children on the other hand were seen as reliable and dependable. Participants commonly stated that they felt attracted to the

innocence of children and felt safe and understood. One participant described how he felt when in the presence of the children in his offence:

"I felt at peace with them, I felt they understood me, I felt close to them. I felt better able to communicate with them".

Participants commonly described pervasive feelings of emotional loneliness and isolation. They associated these feelings with their earlier childhoods and reported being isolated from their peers, as being *"loners*", and as having unmet needs for parental affirmations and affection. They described parents who were ignoring and emotionally unavailable, and of being exposed to limited modelling of healthy intimacy. Being victim of, or witnessing abuse – physical, sexual and emotional – was commonly experienced by all. Their sense of personal worth and lovability appeared to be damaged in childhood. In adolescence they reported being "*loners"*, and this sense of isolation and loneliness continued from adolescence into adulthood. as one man explained:

"*I was on my own a lot of the time, I was isolated"*

Participants explained how they coped with their loneliness by being around children. One participant described how children made him feel "*comforted and confident*" and allowed him to experience "*love and attention*" which he felt he never experienced growing up. Another participant explained that he sexually abused a child because it made him *"feel wanted".* Children's emotional responsiveness and innocence appeared to contrast with the criticism and rejection they knew of adults, and through their sexual contact with children, participants reported satisfying their needs for emotional and physical intimacy.

"I felt that someone does care, I'm not on my own"

"At the time we just wanted to be with each other. It was as if it was our own little cocoon and comfortable"

One participant described his relationship with his victim as being the single most important personal relationship in his life.

"I loved him. I felt at that time I'd found someone where I care about…….We had that kind of bond"

In keeping with the themes of emotional loneliness and isolation, participants' described the different ways in which they isolated the child from other family members, siblings and significant others to make them feel special as a way of ensuring they would not leave them.

"He'd never leave. They'd never leave because you'd treat them, you'd spoil them, you'd buy them presents, take them shopping, take them to the cinema, days out, they'd never leave"

The reported inability of these participants in achieving intimacy and an emotional connection with adults is suggestive of the importance of these factors in their offending.

Entitlement

All participants (100%) in this study expressed a sense of entitlement to sexually offend. Participants reported that their needs were paramount in comparison to others and their sexual offending was specifically to gratify their own needs. For some participants this consisted of sexual needs

"It was purely on, on my part, sexual gratification"

Another offender described how his wife was not satisfying him sexually. Being the father of the house, he felt entitled to use his daughters as a means to satisfying his sexual urges. When asked why he offended against his daughter, he replied:

"Because I wasn't have regular sex with my wife and she wasn't satisfying me"

Because it was his daughter, he stated that he felt he would *"get away with it".*

Another participant reported:

"*I knew there was a problem, but I used to think to myself 'she's mine"*

For other participants, their sexual offending was explained as an act of revenge or protection.

"I knew what I was doing was wrong, I just couldn't stop myself I was so angry I just wanted to get locked up. That's all I was interested in"

Another participant described how the sexual abuse of the child was about his needs as opposed to giving any consideration to the child:

"I just wanted to belong to something. Don't give a shit what it was or what I had to do to get it"

> *"I held myself for a minute as I knew it was wrong but then I chose to have sex"*

One participant believed he was entitled to hurt others because he had been abused

> *"I actually felt at the time that I had the right to go and abuse others"*

One participant described how at the time of his sexual offence he was living his life according to his own rules and was not constrained by laws. He stated that he did whatever he wanted to do, regardless of who this hurt.

"*If I'm honest I didn't really care about anybody else as long as I got what I wanted"*

"If I thought of something I would do it".

Despite the underlying need, participants reported feeling entitled to sexually abuse a child to fulfill their needs.

Miscellaneous

In terms of the main research question, evidence for all of Ward and Keenan's (1999) child sexual offenders' implicit theories was found. There were several statements which, in their independent analysis, the raters could not categorise into any of Ward and Keenan's (1999) pre-existing implicit theories. In the identification

of implicit theories, there was agreement between raters that there was a miscellaneous category. Raters analysed the statements in this miscellaneous category and felt that some of the statements were not indicative of any separate, alternative thematic categories which were not already sufficiently captured by Ward and Keenan's (1999) existing implicit theories. Some examples of these statements included:

"'*the risk of being caught was exciting"*

'I was hoping people would just forget about me"

"I just couldn't cope with it because I've got children of my own"

"that's how I feel like Im not no good to nobody"

However, in over half the transcripts, there were several statements which raters felt illustrated the participant's sexual interest in children. Participants often described the physical attributes of the child which aroused them. A small number of statements appeared to indicate that offenders perceived children as sexually arousing and attractive, including:

"She was beautiful, blue-eyed, big beautiful round eyes"

"I was just wrapped up in her"

"the way she was, her soft skin, she had soft, soft skin and just so hat I can touch her"

"I think she's attractive"

"I saw her as a little girl. I saw her as something I'd like to touch. Very attractive"

"So you know my mind was going I fancy her, I wouldn't mind touching her and getting closer"

"They're [kids] nice. What would it be like to do what I've been doing if I was free?"

"I like them, that they're cute, they've got that kind of innocence about them".

Raters explored this unclassified data and collectively agreed that it did not appear to fit into any of Ward and Keenan's (1999) five pre-existing implicit theories. As is illustrated by the above examples, the offenders are not saying that the child wanted sex or enticed them in anyway, which is a suggestion in the *Children as Sexual Beings* implicit theory as described by Ward and Keenan (1999). Instead, their offence supportive cognitions are solely concerned with their own sexual arousal to the child and their own sexual interest in the child. Consequently, these cognitions appear to be different to those associated with the *Children as Sexual Beings*.

However, it is recognised that in a recent study by Beech, Parrett, Ward and Fisher (2009) assessing female sexual offenders cognitions, cognitions illustrating sexual arousal and attraction to children such as these were classified under the *Children as Sexual Objects* implicit theory. Thus, there appears to be a lack of clarity and agreement as to what type of cognitions are captured by the *Children as Sexual Beings* implicit theory and further research is needed to examine whether an additional implicit theory associated with themes of deviant sexual interest and attraction to children, *Children as Sexually Attractive,* should be created and partitioned out from the implicit theory of *Children as Sexual Beings*. If further research supports such a theory as being distinct, it should be separated out from children being seen as sexual agents to them being perceived as sexually attractive.

Question 2: Will diagnosis impact upon the type of implicit theories held by chills sexual offenders with a mental disorder?

This question sought to explore whether participants' diagnoses would effect the type and presence of implicit theories in this sample of child sexual offenders. The main noticeable difference between the three child sexual offender groups

concerns the *Children as Sexual Beings* implicit theory. This was present in all of the child sexual offenders with a diagnosis of personality disorder (n = 5; 100%) who also endorsed the view that children were sexually attractive and reported deviant sexual interest in children. In comparison, only one child sexual offender with a mental illness reported perceiving children as sexual beings. Instead all of these offenders reported the *Uncontrollability* implicit theory (100%) and in over half of them, this was the theory they predominantly reported. Their offending appeared to be more related to their uncontrollable sexual and emotional needs than to a deviant sexual interest in children.

Participants with a dual diagnosis did not express any cognitive distortions associated with the *Children as Sexual Beings* implicit theory or a deviant interest in children. Instead, their sexual offending appeared to function as a way of protecting themselves in a scary world where they felt entitled to harm others in the process (*Dangerous World* and *Entitlement*), or as a way of releasing their intense feelings of anger and rage which they felt unable to control (*Uncontrollability*).

As a whole, these findings suggest that in this sample of child sexual offenders, the offending of those men with a personality disorder appears to be more related to a sexual deviant interest in children, whereas for those with a mental illness the theme of uncontrollability was predominant. Because of the small number of participants in each of these diagnostic subgroups, these results are not conclusive but they do highlight some interesting patterns in the offender groups which would benefit from further research.

The different clusters of implicit theories were not just suggestive of between group differences, but also appear to indicate participants' varying perspectives about themselves and their offending. For example, participant one showed a very high frequency of the 'Uncontrollability' implicit theory (n=17), whereas no evidence was found of him seeing children in a sexual way. This may suggest he does not consider his child sexual offending behaviour to be sexually motivated but instead considers himself to have little control over his behaviour, including management of his sexual needs. In contrast, the most frequent reported implicit theories for

participant 10 were 'Uncontrollability' (n=12) and 'Children as Sexual Beings' (n=15), suggesting he feels a loss of control over his offending behaviour which was sexually motivated. Participant 8 was also sexually motivated with high frequencies of 'Children as Sexual Beings' (n=15) and 'Nature of Harm' (n=15) implicit theories. This may indicate his offending was sexually motivated and he perceives children as wanting, needing and benefiting from sexual relations with adults. These results are interesting and highlight the heterogeneity in child sexual offenders' theories about themselves, their victims and the world, and their motivations for offending.

Extended Discussion

The current study was an exploratory investigation which sought to identify whether Ward and Keenan's (1999) five distinct child sexual offenders' implicit theories could be used to classify the cognitive distortions in a sample of male high secure child sexual offenders with a mental disorder. These include *Children as Sexual Beings*, *Nature of Harm, Uncontrollability, Dangerous World* and *Entitlement*. Results indicated that the majority of the cognitive distortions exhibited by this sample of men could be categorized within the five implicit theories. Participants also reported cognitions describing their deviant sexual interest in children, which were not felt to fit any of Ward and Keenan's (1999) pre-existing implicit theories, suggesting the presence of a new implicit theory, *Children as Sexually Attractive*. Additionally, child sexual offenders whose offending had strong links with intimacy deficits were not felt to be adequately captured under the *Dangerous World* implicit theory, with the 'Lonely World' theme thought to be more fitting to capture this group. Finally, diagnostic differences between the participant groups were explored. Although tentative, the results suggested there was a common trend for the *Children as Sexual Beings* implicit theory to be reported more commonly in participants with a personality disorder diagnosis. This group was also more likely to report deviant sexual interests and sexual arousal to children. Each of these

findings will not be discussed before addressing the limitations and their implications to clinical practice.

Participants' cognitive distortions as illustrated by their interview transcripts provided further support for Ward and Keenan's (1999) five distinct child sexual offenders' implicit theories. Ward (2000) proposed that child sexual offenders' implicit theories conceptualise children as possessing certain cognitive capabilities and beliefs as well as specific desires, wants and preferences. He also proposed that these implicit theories determine how certain information is interpreted and whether it is seen to be evidence supporting or refuting their implicit theory. This was demonstrated by the men in this study.

Children as Sexual Beings

Participants holding the *Children as Sexual Beings* implicit theory (50%) described children as having sexual desires and beliefs and reported interpreting information from the child to fit with their implicit theory. For example, they reported commonly perceiving sexual intent in the child's normal everyday behaviour. These included a child sitting on their lap; a child running around in underwear; a child hugging them. Any information that conflicted with this was either ignored or changed to fit with their theory. For example, interpreting the child's silence as permission to sexually abuse. This demonstrates how these child sexual offenders appeared to perceive children and their behaviours in a sexualised way fitting with their underlying implicit theory and behaved in accordance with their implicit theory. These men also reported that they felt that the children in their offences had the capacity to identify sexual practices and behaviours that satisfy them and to make decisions about how to fulfill them and with whom. Generally, children did not appear to be seen by these men as needing special protection because of their youth and vulnerability, or their lack of sexual experience or sophistication. Instead, the power balance appeared to be exploited with the relationship being described as if the child was equal in status. This finding appears to support previous studies acknowledging the acceptance of adult-child sexual relations in child sexual offenders (e.g. Marshall, Hamilton & Fernandez, 2001; Marziano et al., 2006; Stermac & Segel, 1989).

Nature of Harm

The *Nature of Harm* implicit theory commonly occurred with many of the other implicit theories and as Ward (2000) proposed, appears to be secondary to and used in conjunction with them. In particular, participants who perceived children through the sexual lens of *Children as Sexual Beings* frequently reported cognitions suggestive of the *Nature of Harm* implicit theory. Seeing the child in this way, as someone who was sexually active and wanting sex, appeared to blur the boundaries of social acceptable sexual behaviour and offenders reported how they felt that engaging in sex with the child was appropriate and harmless. They did not define their behaviours as abusive but appeared to see them as being beneficial to the child in some way. The appeared to interpret the child's reaction to the sexual abuse as being neutral or favourable. When they perceived that the child did not resist, had no reaction, or seemed interested, they interpreted this as permission to ignore inhibitions and continue the abuse. This does not imply that the child colluded in the contact but further demonstrates how offenders perceive and interpret their victim's desires, wants and needs to fit their underlying implicit theory. Again, these beliefs remained consistent in light of contradictory evidence which participants appeared to change so that it fitted with their prevailing theory. For example, one participant refuted the child's claims that it hurt her as a "*once off*" and instead focused on her behaviours which indicated that she had "*got used to it*" he saw as evidence that she enjoyed it.

Uncontrollability

Participants commonly described having 'uncontrollable' sexual and emotional needs which they felt driven to fulfill. This *Uncontrollability* implicit theory appeared to be self-fulfilling for offenders as believing their behaviour to be outside their control, acting out their needs in the form of sexual abuse was seen to be justified, inevitable and outside of their responsibility. The most commonly cited factors were anger, paranoia, emotional needs (e.g. loneliness) and sexual urges, which these men sought relief from through the sexual abuse of a child. An interesting finding was the low number of men who made reference to their mental illness as having

played a role in their offending. Only two of the seven men with a diagnosis of mental illness felt it played a role in their sexual offending. Both participants described experiencing persecutory thoughts which potentiated and reinforced their long standing paranoia and general suspiciousness of others (linked to *Dangerous World* implicit theory) consequent to their earlier experiences of abuse. Thus, although their sexual offending occurred in the presence of positive symptoms of mental illness, their offending appeared to be linked to more long standing deficits developed pre-morbid rather than the direct effects of mental illness. They also reported histories of antisocial and non-sexual violent offences and appear to similar to group three of Drake and Pathe's (2004) typology of mentally ill sexual offenders, which describes men whose deviant sexuality is a manifestation of more generalised antisocial behaviour. Based on these findings, it suggests that the sexual deviant behaviour in this sample of child sexual offenders with mental illness did not necessary arise from the mental illness itself but rather as a result of pre-existing developmental vulnerabilities, personality features and deficits in social functioning (e.g. most reported heterosexual difficulties prior to offending). This finding appears to support existing studies which indicate that mental illness alone does not account for sexual offending behaviours (Smith, 2000).

Dangerous World

Dangerous World implicit theory present in 75% of the men appeared to clearly guide their information processing towards perceiving threats where evidence was absent or ambiguous, and support their abusive behaviour towards others as a pre-emptive action to prevent harm to their self. Most of the men (seven) who reported cognitions supporting this theory demonstrated evidence for the second variant of this theory, and viewed children as a source of safety and comfort and an opportunity for developing an emotional connection in a world where adults were threatening and to be avoided. Only two men reported cognitions fitting the first variant of this implicit theory and for them, there were no entities that were perceived as being exempt from these core beliefs. They saw the world and everyone in it as being hostile who they had to control and dominate (through non-

sexual and sexual abuse) instead of themselves being exploited. Because this theory invites hostile attitude from others it was also felt to be self-fulfilling for these offenders. *Dangerous World* and *Entitlement* implicit theories commonly worked in tandem to justify and support participants' exploitative and harmful behaviour towards others.

Entitlement

The need for, and foremost importance of self gratification was common to all participants holding the *Entitlement* implicit theory. As previously found by Polaschek and Gannon (2004), this implicit theory is self serving. For this group of child sexual offenders it appeared to legitimise their perceived importance and right to dominate others, promoting participants' pursuit of their own needs while providing justification for ignoring the child's needs, wants and desires. Some were preoccupied with sexual urges and felt entitled to satisfy them, irrespective of harm they were causing. For others, emotional needs were more prominent (e.g. to seek revenge, to feel loved). Regardless of the need, all participants appeared so focused with meeting their needs that they ignored all other aspects of the situation and the child's wants and needs. Participants' sense of entitlement appeared to develop from their earlier abusive environments, as well as from social learning. For example, witnessing their father using violence and sex to get his needs met; other family members or significant others in their lives modeling cognitions and other behaviours that provide evidence of the theory that men have special entitlements either generally or relative to others. Participants' elevated sense of self importance served to overcompensate for earlier attacks on their self worth and defend against further threats to their self esteem, emotional isolation and protect themselves from further being a victim to the world.

Miscellaneous

One of the more interesting finding of this study concerned the statements which were not found by raters to fit any of Ward and Keenan's (1999) pre-existing implicit theories. Raters found one cluster of items that could potentially indicate the

existence of a new implicit theory, *Children as Sexually Attractive,* and concerned with men's deviant sexual arousal to children. Half the sample of child sexual offenders in this study reported cognitions demonstrating evidence for their sexual arousal and attraction to children which was a driving factor in their offending. Raters felt this theme was different to Ward and Keenan's (1999) description of the *Children as Sexual Beings* implicit theory, which focuses predominantly on the offender's belief that children are sexual beings and his interpretation of their behaviour, rather than the offender's sexual preferences irrespective of the child's behaviour. It is interesting that in the mental illness group, the cognitions of two participants were categorized under the *Children as Sexual Beings* implicit theory or under the miscellaneous category as representing paedophilic interests in children. This may suggest the difference and exclusivity of these two themes and provide support for this theme to stand alone as a separate theory to the *Children as Sexual Beings* implicit theory. Alternatively, it may highlight the need for the *Children as Sexual Beings* implicit theory to be expanded so that it accounts for this sexual deviancy which offenders frequently report.

This paedophilic interest in children has long been cited as an important precipitating and maintaining factor in the sexual offending of children. Finkelhor (1984) argues it is a necessary precursor for sexual offending to occur, and other aetiological models include it as an influential and necessary factor. Groth (1979) devised typologies of child sexual offenders, categorizing them according to the presence or absence of deviant arousal to children. This typology has since been challenged by other researchers although it is recognised that not all child sexual offenders are sexually attracted to, or aroused by children. There is also considerable evidence that deviant arousal and attraction to children is predictive of persistent sexual offending (Hanson & Morton-Bourgon, 2005). Thus, accurately identifying and targeting this in treatment is important in efforts to reduce risk of re-offending. Further research is necessary to explore whether this theme exists independently to the *Children as Sexual Beings* implicit theory.

Lonely World versus Dangerous World

Another interesting finding in this study was the noticeable difference between the men who categorised under the two variants of the *Dangerous World* implicit theory. The sexual offending of the men holding the first variant was reported as being driven by rage, anger and as a way to seek revenge and escape from society, as opposed to involving any sexual interest in the child. They did not appear concerned with the child's needs or desires and were commonly strangers to the child, describing their offending as opportunistic. Their sexual offending was part of a long criminal history of antisocial offences. In contrast, the sexual offending of the men holding the second variant appeared to be their way of meeting both their sexual and emotional needs. They reported being emotionally lonely and isolated from adult relationships due to earlier attachment difficulties. In light of these interpersonal and intimacy deficits, they described being blocked from adult relationships and feeling more comfortable and relaxed in the company of children. A sense of their isolation was reflected in the ways in which they separated victims from their supportive social environment in order to engage the child in sexual activity. For example, separating the child from his/her other siblings making the child feel more special with efforts including giving the child treats; playing the role of the 'trusted' babysitter ensuring alone time with the child. All the children were treated with favouritism, revealing offenders' own loneliness and their hope that their victims could alleviate that loneliness.

These two subgroups of child sexual offenders appear to be very different in terms of their criminal histories, cognitions and motivating drive for offending against children. For example, participants holding the first variant described their offending as a way to seek revenge or a way of protecting themselves from being a victim of others. However, the sexual offending of the participants holding the second variant appeared to be driven by their need to belong to someone and protect themselves from further abandonment, rather than protection from the world and others per se. The emotional tone of these men also reflects the different treatment needs of these groups. For example, treatment of those men expressing feelings of anger

and hostility would need to address their global mistrust and suspiciousness of others, and working on linking these perceptions to earlier developmental experiences. On the other hand, feelings of isolation and emotional loneliness are linked with social anxiety and vulnerability. Therapeutic needs would look at modifying the offender's beliefs about acceptance and likeability, making links with earlier experiences and promoting social integration.

Although Ward and Keenan (1999) categorise these two subgroups of child sexual offenders under the *Dangerous World* implicit theory, it was felt that in light of the diversity between these men, subsuming them under the same theory appeared to lose sight of the differences between these men. Additionally, given that the majority of men in this sample articulated cognitions associated with the second variant, the theme of 'Lonely World' as opposed to *Dangerous World* was felt to be more accurate in describing this subgroup of child sexual offenders. The low reporting of hostile thinking by the child sexual offenders in this sample supports previous studies indicating that this thinking is more commonly found in rapists and intimacy deficits and sexual preoccupation are most salient factors for child sexual offenders (e.g. Mann & Hollin, 2001). It may be that the *Dangerous World* implicit theory is more fitting for adult sexual offenders and a 'Lonely World' is better suited to child sexual offenders.

The importance of this theme of emotional loneliness is also supported by other researchers including Hartley (2001) and Ward et al. (1993) who both found intimacy to be an endorsed motive in their sample of child sexual offenders. Additionally, Finkelhor's (1984) etiological theory stresses the importance of this idea of emotional congruence as a motivating factor in child sexual offending. This was also confirmed by Hanson and Morton-Bourgon's (2005) meta-analysis of risk factors for sexual offending, where emotional congruence with children was one of the factors found to have significant relationships with recidivism. Given the recognised importance of intimacy and loneliness in child sexual offenders, and the high reporting of these factors in this study, it is felt that further studies should explore this further to determine whether it is deserving of a new implicit theory,

'Lonely World, or a more elaborate extension of the *Dangerous World* implicit theory.

Question 2

There is preliminary evidence that different types of child sexual offenders exhibit distinct types of cognitive distortions (Ward et al, 1997). The main difference between the child sexual offenders in this sample concerned their clinical diagnosis and the second question guiding this study sought to explore whether participants' diagnoses would impact upon the presence and content of their implicit theories. Although comparison of the implicit theories across the diagnostic groups was hindered by the small sample size, findings appeared to suggest that in this sample of child sexual offenders, all participants with a diagnosis of personality disorder articulated distorted cognitions representative of the *Children as Sexual Beings* implicit theory (n=5; 100%) and also reported deviant sexual arousal to children. Such beliefs are typical of the more fixated paedophilic child sexual offender (Groth, 1979). The two participants with dual diagnosis reported no sexual attraction to or interest in children and their offending was more linked with the *Dangerous World* (revenge) and *Uncontrollability* implicit theories (release of anger and sexual frustration), both acknowledging their mental illness as potentiating their pre-existing paranoia. In the mental illness group, only one of the participants disclosed sexualized views of children. All of the men revealed cognitions fitting the *Uncontrollability* implicit theory and reported being unable to control their sexual urges more commonly than any other factors. This finding may be supportive of previous research where mental illness was found to act as a possible disinhibitor (e.g. Crassati & Hodes, 1992) and breaks down a person's normal inhibitory controls leaving them unable to look beyond their immediate aim, to the nature and consequences of their actions. By definition, disinhibition assumes the prior existence of factors relating to the propensity for sexual offending. As participants also reported distorted cognitions and other motivating drives, it may be that their mental illness acted with other potentiators to sexual offending at the time of the offence rather than operating as an isolated causal factor. This is consistent with

the finding that only two of the seven participates considered the role of their mental illness in their sexual offending. Overall, these findings appears to mirror previous studies that identify personality disorders and cognitions as risk factors in sexual offending as opposed to mental illness (e.g. Smith, 2000) and highlight some interesting lines of inquiry for further research projects.

It should be noted that the theme of uncontrollability was felt to be limited in its ability to further an understanding of an individual's reasons for offending. In this study, for example, some participants exhibited cognitive distortions related to internal uncontrollability (e.g. sexual urges), or external uncontrollability (drugs), whereas others related it to both. Although these cognitions were categorised under the *Uncontrollability* implicit theory, the understanding of why these men sexually offended appeared superficial. One of the participants, for example, who explained his sexual offending as being caused by his uncontrollable sexual urges also described being able to control his urges using masturbation and visiting prostitutes. He also stated that he gave the child in his offence the option of having sex with him, which does not appear to support his reported belief that he could not control his offending. Thus, one would question how this theme of uncontrollability actually functioned for him. Furthermore, we do not know from participants' statements of uncontrollability whether it means that uncontrollability represented a general trait for these individuals, which would suggest they perceived themselves as individuals who were uncontrollable, or whether it represented a specific trait for these individuals and functional to certain situations or people? This is an important distinction in terms of the risk they pose as well as treatment implications. An offender who attributes his reported uncontrollability internally for example, could be considered to be more amenable to treatment in terms of assuming greater personal responsibility for their behaviours. Whereas those offenders citing uncontrollability related to external factors may perceive themselves as being less accountable for their behaviours, "projecting" blame and responsibility to others or onto particular circumstances. Overall, the theme of *Uncontrollability* was felt to be

very broad and superficial and such statements would need to be explored further with an offender to develop a more specific understanding of his offence process.

Results also indicated that child sexual offenders exhibit distinct types of implicit theories to one another (Ward et al, 1997). As was highlighted, the offending of some men appeared to be sexually motivated, for others they appeared to be driven by anger, whereas others appeared to be driven by a loss of control over their behaviour. This suggests that knowledge of offender's unique implicit theories is important as this can provide information as to how an offender views himself, his victim and his offending, which allows for specific interventions unique to the offender's needs and risks to be developed. Furthermore, awareness of an offender's implicit theories can to some extent be used by the therapist as an indicator of how best to engage and work with him. For example, an offender with high frequencies of 'Dangerous World' implicit theory alerts the therapist to his potential enduring beliefs regarding the untrustworthiness of others and the possibility that more effort may be required in the initial stages of building a therapeutic relationship with him and maintaining his engagement in therapy. This focus on building and enhancing the therapeutic attachment also work towards managing the individual's risk as delivering an intervention in a style that is responsive to his needs increases the likelihood of his engagement in therapy.

Cognitions bridging more than one Implicit Theory

Participants in this study often articulated cognitions bridging more than one implicit theory. For example, men who articulated cognitions suggestive of the *Children as Sexual Beings* implicit theory also reported that children were not harmed by sex (Nature of Harm implicit Theory). This blurring of boundaries questions the clarity of distinction between some of Ward and Keenan's (1999) implicit theories and whether they are indeed independent robust theories. The implicit theory approach was developed as a way of organising cognitive distortions as opposed to a framework for analysing the function and role of an offender's cognitions. Given the fact that the same cognitive distortion can be tapping into different implicit theories,

identifying the function of the cognitive distortion in an offender's offence process is necessary to develop an understanding of his offence behaviour and formulate an appropriate treatment intervention.

Clinical Implications

This study provided evidence of Ward and Keenan's (1999) five distinct child sexual offender implicit theories in high secure child sexual offenders with a mental disorder. All participants articulated cognitive distortions representative of more than one implicit theory which were maladaptive and shown to consist of false beliefs and misperceptions, which appeared to influence in their sexual offending behaviours. Evidence for these implicit theories was demonstrated by all participants, irrespective of diagnosis. This would appear to support previous findings identifying cognitions as risk factors to sexual offending in mentally ill and non-mentally ill sexual offenders, proposing that psychosis alone is not a sufficient motivator for sexual offending and cognition plays an influential role (Smith, 2000). Pre-existing personality difficulties appeared to be more prevalent and influential in the offences (e.g. intimacy deficits, cognitive styles). These results also matched the dynamic risk factors associated with sexual offending - sexual preoccupation, deviant sexual interests and emotional congruence - as evidenced by a meta-analysis by Hanson and Morton-Bourgon (2005). Because cognition is a pervasive characteristic, the type of explanatory cognitions underlying an offender's sexual offending will be similar to those underlying their general explanatory theories. This has impacts upon assessment and treatment of these men.

First, regardless of diagnosis, offenders' implicit theories should be identified and addressed in therapy by therapists. As noted in the introduction to this paper, most treatment programs address cognitions of denial and justifications for offending. However, if the underlying implicit theories which give rise to these cognitive distortions are not explored, efforts to reduce the influence of specific cognitions on information processing and decision making are unlikely to be successful as the underlying theory that generates them will remain in place, strengthening itself by biasing incoming information all of the time. Thus, the offender's maladaptive ways

of conceptualizing children will remain leaving him at risk of relapse and committing further sexual crimes.

Secondly, this study demonstrated the depth of characterlogical disturbance and the complex interplay between participants' personality and mental illness which suggests the importance of individual formulations and treatment plans. Treatment should address both the personality disturbances as well as the mental illness, in addition to the offence behaviours. This is particularly important given that treatment interventions for child sexual offenders with a mental illness focus predominantly on managing the psychotic symptoms. Whilst anti-psychotic medication is an important treatment, there is a need to consider other factors if the nature and level of their future risk is to be effectively managed.

Third, awareness of an offender's implicit theories can help therapists in developing initial working formulations of their offending and in identifying important treatment targets to mange risk in individual treatment plans. For example, those offenders who report high frequencies of the 'uncontrollability' implicit theory may require a heavier focus on building the individual's behavioural and emotional management than those with frequencies of the 'dangerous world' implicit theory, who may benefit more from work focusing on interpersonal difficulties. Current sexual offender treatment programs mostly consist of cognitive behavioural approaches where little emphasis has been placed on the role of underlying schematic beliefs and personality. Furthermore, although these interventions appear effective in reducing recidivism in sexual offenders, the effect sizes obtained are modest (Ward, Nathan, Drake, Lee & Michele, 2000). The presence of cognitions that excuse, justify or rationalise offending behaviour have been found to have little impact on risk, whereas the underlying presence of offence supportive attitudes and implicit theories have been found to raise risk when present (Hanson & Mourton-Bourgon, 2005). Consequently, schema-based intervention programs (Young, 1990), which target these underlying cognitions, are currently being proposed as effective for working with sexual offenders in reducing both cognitions

and underlying implicit theories. This requires further investigation as only preliminary data exists (Thornton & Schingler, 2001). Also, schema focused interventions were initially developed for treating personality disorders and it would be interesting to examine their effectiveness with non-personality disordered individuals, as this study has shown that underlying beliefs are not restricted to those with personality disorders.

A fourth implication concerns how the identification of implicit theories could to some extent be used by the therapist as an indication of how the offender may engage with and respond to therapy. For example, offenders with enduring beliefs regarding the untrustworthiness of others (Dangerous World implicit theory) may require more effort in the initial stages of building the therapeutic relationship and maintaining engagement in therapy. Thus, the attachment between therapist and client will be important. Furthermore, in light of the offender's developmental vulnerability being shown to play a role in the development of implicit theories and child sexual abuse, therapists should integrate interpersonal tools in the therapeutic method.

Fifth, this study found that there was a high reporting of deviant sexual interests in children by participants with a diagnosis of personality disorder. Child sexual offenders who have personality disorders and deviant sexual interest in children are thought to be less likely to inhibit their sexual urges and obtain sexual gratification opportunistically (Bogaerts et al., 2006). Consequently, this would suggest that effective management of this group of child sexual offenders will require knowledge of the factors that indicate risk of re-offending, and individualized treatment plans addressing their offending behaviours, deviant fantasy as well as their personality and cognitive factors supporting their sexualized beliefs and interests in children.

Sixth, as previously mentioned, Ward and Keenan's (1999) implicit theory hypothesis provides only an organising framework for the cognitive distortions generated by child sexual offenders and does not inform our knowledge about their origins or function in the offender's sexual offending, or how best to conceptualise

and work with these statements. How different cognitions may be present and function at different phases of an offenders' sexual offence has long been debated. For example, are cognitive distortions functioning as pre-offence precipitating statements or post offence self-esteem maintenance strategies? This debate has not been resolved. Given the heterogeneity of child sexual offenders, what is suggested here is that the content and function of their cognitions in their offending is likely to vary. This raises questions concerning how therapists should address child sexual offenders' cognitions. Working with the hypothesis that not all offence supportive cognitions are present pre-offence but are often used as post-offence dissonance reduction and self-esteem maintenance strategies common to all individuals would suggest they may not be influential in the initiation of the sexual offence and thus of limited relevance in terms of treatment targets. Proeve and Howells (2006) have cautioned against challenging self-protective cognitions in child sexual offenders experiencing high levels of shame and guilt as it is likely to further increase guilt and result in disengagement. This not only inhibits an understanding of an individual's offending being developed, but also the management of his offending risk.

Alternatively, taking the position that cognitive distortions are present pre-offence and act of precursors to an individual's sexual offending suggests not only their importance in his offence cycle but also their importance as treatment targets to help reduce risk of re-offending. It is important to work collaboratively with the offender to ascertain the function of his cognitions, and how they are associated with indicators of change as well as risk. Ward and Keenan's (1999) may be useful in terms of helping an offender to develop an understanding of the different types of cognitions he had during his offence, and mapping these onto an aetiological model of offending, like Finkelhor's (1984) Precondition Theory, would be useful in developing an understanding of how the different cognitions functioned for him at different stages across his entire offence process, highlighting those which acted as precursors and are important for change.

Methodological Considerations and Future Research

This preliminary study has highlighted interesting and important possibilities in this under-researched group of child sexual offenders. The methodology employed in this study, however, has some limitations and this warrant cautious interpretation of the results. These are now discussed as well as suggestions for future research which is needed to expand knowledge in this area.

Reliability of Findings

Study Design

The design of this study relied solely on the self report of participants and on their accurate self-perception and honesty in response. An understanding of child sexual offenders' offence supportive beliefs by self report has inherent difficulties. The first of these concerns the reliability of these reports. A large body of research exists cautioning against the use of self-reports from child sexual offenders as sexual offenders can and do purposefully modify their self-report responses to present themselves in socially desirable terms (Hayashino et al., 1995). Some may be invested in presenting themselves in a positive light, for example, to become eligible to move to lower security or for legal reasons. Thus, it could be argued that because the implicit theories reported have been constructed from the self reported cognitions of child sexual offenders, they are not necessarily representative of child abusers' beliefs.

A number of steps were taken to address the potential for unreliable data as a result of self-report. For example, all interviews were conducted face to face by the same researcher, establishing rapport and facilitating information gathering. All participants were reminded frequently that their interview transcripts was confidential and would not be made part of their clinical records and engagement in the research was not in any way connected to, or consequential, to their treatment. Participants had also consented freely to the research and were informed that they could withdraw at any stage. In light of this, it was hoped that this would help in reducing their motivation to present themselves in a more positive light, as they

would have gained little from doing so. However, as with all contemporary measures of self-report, disingenuous responding cannot be ruled out completely. A reliable and valid scale may have enhanced the investigation by incorporating a measure of concurrent validity in terms of the findings. However, many of the scales used to assess cognition in sexual offenders have been found to be restrictive in terms of content areas, lack face validity (Bumby, 1996), and suffer from social desirability response bias (Hall, 1990). Hence, due to the degree of transparency and lack of discriminatory usefulness, their overall utility as assessment tools and indicators of treatment progress is reduced (Langton & Marshall, 2000).

A second difficulty in using self-reports methods is that participants' explanations are determined by their personal insight and ability to verbalize emotions and cognitions. Ward (2000) has argued that offenders' cognitions are not always consciously accessible and thus may not be reported. However, it was hoped that by using the interview approach, and by directing participants to take some time to 'put themselves back to the time of their offence', the narrating of their offences would prime offenders' memory and ability to access cognitions. Currently, there has only been one other study exploring Ward and Keenan's implicit theories in child sexual offenders (Marziano et al., 2006). Thus, caution needs to be used when interpreting the meaning of these results, as well as from the fact they are all based on self-report designs. This suggests that triangulation of method and information sources would provide more reliable measures of detection and exploring the function of such cognitions. For example, including implicit measures of cognition (e.g. Dawson, Barnes-Holmes, Gresswell, Hart & Gore, 2009; Nunes, Firestone, & Baldwin, 2007), which are thought to be more robust and reliable measures of cognition.

Another possible shortcoming was the composition of the sample, which was unequal in terms of treatment exposure and the number of intra-familial and extra-familial offenders. Intra-familial offenders are thought to be generally less distorted than extrafamilial offenders and to have less pervasive beliefs legitimising the

sexual abuse of children (Hayashino et al., 1995). Thus, it is likely that had the sample included equal numbers in terms of offender type, there could have been different outcomes from the data in regard to theories endorsed. Furthermore, treatment effects were not controlled for. Some of the participants had completed treatment, whereas others were currently engaged in treatment at the time of the study. For those men who had undergone treatment, presumably intervention would have included cognitive restructuring. Hence, treatment may have affected the content and number of cognitive distortions exhibited at interview.

Demand characteristics on the part of the participants may have impacted on the elicitation of cognitive distortions during the interviews. Gannon and Polaschek (2006) have argued that treatment may reduce offenders' accessibility of their implicit theories. It may be that offenders who had undergone treatment may have been more effective in terms of actively monitoring their cognitions, and misrepresenting themselves. Alternatively, it may be that due to the effects of treatment, they had increased their level of self-awareness and may have been less defensive, with the result being an increased ability to present "truer" accounts of their offending, including cognitions.

Future studies should control for offender type and level of treatment exposure to enhance the validity and generalisability of findings. Additionally, further research based on investigating pre and post treatment levels of implicit theories may be useful to elucidate the individual tenacities of these categories.

Data Coding and Analysis

Raters were aware of participants' allocated diagnostic category prior to coding their transcripts. This could have potentially introduced bias into their coding as, for example, raters may have had prior expectations of the types of implicit theories which would be exhibited by the different diagnostic groups. Future studies should control for this by ensuring independent raters are unaware of participants' diagnostic categories until completing their coding.

The reliability of findings could also be questioned by the usage of and the first author's role in the content thematic analysis of the data. However, the degree of 'triangulation' in the form of other raters' analysis of participants' interviews is thought to offer protection from subjective and biased results and enhance the reliability and credibility of the findings of this study. Furthermore, as the identified themes in this study are all supported within the literature and have helped illustrate the offending behaviour of the participants, it is felt that a degree of external validity can be ascribed to them.

Generalisability of Findings

Sample Size

Only twelve child sexual offenders participated in this study. Although this sample size appears small, it consisted of half the population of interest and can be seen as a good representation of high secure child sexual with a mental disorder who are admitters to their sexual offending behaviours. Additionally, other studies using similar sample sizes (Craissati & Hodes, 1992; Phillips, Heads, Taylor & Hill, 1999) or even smaller sample sizes (Jones et al., 1992) have still made a contribution to this area.

One difficulty with the sample size besides the generalisibility was the small numbers in the diagnostic subgroups. This made it difficult to draw any comparisons between the content of implicit theories in the different diagnostic groups. Also impacting on the generalisability of findings is the fact that all participants were drawn from the same single maximum security hospital and may have potentially been prone to geographical bias. Although participants were recruited from the same hospital, it has a large and diverse catchment area. Additionally, the sample was heterogenous with regard to diagnosis (e.g. mental illness, personality disorder, or both) and offence type (e.g. intrafamilial and extrafamilial child sexual offenders). It is hoped that this helped to contribute to an understanding of these diagnostic and offence specific individuals who are challenging to clinical management in special hospitals.

It would be interesting to replicate this study on a larger sample of child sexual offenders from different high secure hospitals, as well as from hospitals of lower security. Additionally, incarcerated or community based child sexual offenders with a recognizable mental disorder who have or are receiving treatment for their sexual offending should be examined. Research utilizing an undetected sample of child sexual offenders may also increase our understanding of the role of cognition in child sexual offending (Kaplan, Abel, Cunningham-Rathner, & Mittleman, 1990). An increased sample size may assist in elucidating further cognitive differences between the various offender types. Ascertaining whether implicit theories are present in diverse groups of child sexual offenders with a mental disorder will help to validate these findings and inform us of the generalisability of these findings.

The use of diagnosis

Participants were identified on the basis of having a clinical diagnosis of mental illness, personality disorder, or a dual diagnosis of both. A problem with distinguishing individuals on the label of 'mental illness' or 'personality disorder' is that such individuals are seen to be a homogeneous group and the unique number of and interaction between personality, demographic and environmental factors that effect all of these individuals' behaviour are ignored. Furthermore, in those patients with a dual diagnosis, it is difficult to determine what is contributing to the offending behaviour and to what extent, the mental illness or the personality disorder.

Different personality disorders are thought to affect behaviour differently. This has also been found to be true of sexual offending behaviours although the conclusions drawn are not exhaustive. In this study, offenders' specific personality diagnoses were not controlled for but grouped under the common term of 'personality disorder'. Thus, examining whether there are differences in the cognitions and implicit theories of child sexual offenders with different personality disorders was not possible. Given the inconsistent findings regarding the role of specific personality disorders in sexual offending, it would be interesting to examine whether specific personality disorders are predictive of certain implicit theories.

Critical Reflection

This study used a content analysis approach (Weber, 1990), which is primarily concerned with what people talk about the most and how themes relate to each other. As previously mentioned, this approach is seen to be both qualitative and quantitative. However, as opposed to other purer qualitative methods of phenomelogical inquiry (e.g. grounded theory), I felt that content analysis restricted my freedom to explore or interpret in any depth the meaning of participants' cognitions. This was when I found it difficult to remain in the researcher role and adhere to an interview schedule as opposed to moving into the familiar therapist role, where freedom to explore responses further, including ambiguity and inconsistency, would be granted.

This sense of feeling restricted was also reinforced by the use of Ward and Keenan's (1999) coding template, which outlined what data was of importance and of relevance, i.e. that which fitted Ward and Keenan's (1999) pre-determined categories. This inevitably meant that other data was left uncoded, which may have been considered important had such a specific focus of analysis not been imposed. Being theory driven, the focus was more on individual statements which appeared representative of Ward and Keenan's (1999) categories, rather than analyzing the interview data as a whole and from the context in which they were made. This method of analysis did not allow me to go beyond the production of these codes and categories to comment on the interviews descriptively, linguistically, and conceptually as would have been facilitated by other methods. Given that this current study was primarily a replication of previous research on Ward and Keenan's (1999) implicit theories in child sexual offenders (although using a different population), I felt that maintaining the same methodology would allow for comparison of findings. However, I feel it would be interesting to revisit this data using an alternative and less restrictive method of analysis, where the aim is to identify emerging themes from the data rather than identifying evidence for pre-determined themes.

In terms of using Ward and Keenan's (1999) implicit theory approach, I feel that one of its main weaknesses concerns its inability to describe or explain the function of these themes in a sexual offence. Except for the Children as Sexual Beings implicit theory, the other four theories are often seen in other non-sexual offenders. Furthermore, not only do some or explain the process of how sexual offending arises out of thinking associated with these implicit theories. For example, a study by Polaschek, Calvert and Gannon (2009) used grounded theory to analyse the offence narratives of serious violent offenders and identified schema variants which I felt could be thought of as similar themes to those implicit theories identified in child sexual offenders. For example, the theme of 'normalisation of violence' schema focuses on normalising and minimising the criminality and harmfulness of violence, which is similar to the 'Nature of Harm' theory which minimises the harmfulness of sexual activity with children. The 'beat or be beaten' schema contains beliefs about the world as a hostile place, which is the focus of the 'Dangerous World' implicit theory. The 'I am the Law' schema consists of beliefs of superiority and entitlement which links to the 'Entitlement' implicit theory. The 'I get out of control' schema contains beliefs about the inability to regulate one's emotions and behaviours, which mirrors the theme of Ward and Keenan's (1999) 'Uncontrollability' implicit theory. Thus, these themes highlighted by Ward and Keenan (1999) as being important in child sexual offending appear to be non-specific to child sexual offenders and shared by other offender groups. On the other hand, paedophilic interests in children, the one factor that has been shown to be specific to child sexual offenders and believed by many researchers to be necessary for its occurrence (e.g. Finkelhor, 1984), is ignored by Ward and Keenan (1999). Having used this approach in this study, I feel that it may be useful in terms of organising and linking different cognitive themes together. However, I was left feeling that I was merely identifying surface level reasons that offenders' often disclose and it felt redundant in terms of facilitating an understanding of the process of how having these cognitions translate into a sexual offence against a child.

Regarding ethics, informed consent was gained from all participants in this study. However, I wondered whether being asked to participate by professionals who are

involved with and to a great extent in control of their care influenced their decision to participate. Additionally, I wondered whether participation was more about having some specified individual one-to-one interaction or a way to fill time than actually wanting to discuss such a sensitive issue as their sexual offending. This made me reflect on the power imbalances which are evident in abundance in secure settings and how as practitioners we may unconsciously, and consciously, be reinforcing these in our everyday practice.

Listening to accounts of child sexual offending was not a pleasant task and I found the content of these interviews to be distressing, with some especially leaving a particular resounding feeling of disgust. I experienced various conflicting emotions during every interview for participants, their offence and for their victim(s), including sadness, confusion, disgust and empathy, which I had to manage both during and after the interview. Although I could appreciate the practical and emotional difficulties reported by many of these men, I often struggled to comprehend how this resulted in the sexual offending of a young child. As clinicians, some of the basic clinical skills we are expected to demonstrate with our clients include empathy, unconditional positive regard and genuineness (Rogers, 1959). I think this can be a difficult request when working with a client group such as child sexual offenders, primarily because their offending behaviour, more so than any other offending behaviour, is particularly difficult for most to comprehend and understand, and which violates not only society's norms, but our own ethical, moral and personal standpoints.

I was particularly aware of my anxiety before interviewing certain participants, primarily because of the nature of their offending. I had preconceived ideas of how they would present and be with me but as was the case throughout the interviewing process, my expectations were not met. Clinical supervision and maintaining a reflective diary were particularly useful to facilitate thinking about the different responses of myself, as well as other professionals to this group, and how this may impact upon our clinical work. The wider literature exploring the effects of working with sexual offenders on therapists (e.g. Moulden & Firestone, 2007) was also

particularly useful in normalizing my emotional experiences. Individual differences and experiences are likely to influence our approach to, and ability to work with this client group. A common theme arising from my reflection was the importance of formulating a holistic understanding of these individuals and their life experiences, of which their sexual offending behaviour is only one part of the puzzle.

Word Count = 29685

References

Abel, G.G., Becker, J.V., & Cunningham-Rathner, J. (1984). Complications, consent and cognitions in sex between children and adults. *International Journal of Law and Psychiatry, 7*(2)*,* 89-103.

Abel, G.G., Gore, D.K., Holland, C.L., Camp, N., Becker, J.V., & Rathmer, B.A. (1989). The measurement of the cognitive distortions of child molesters. *Annals of Sex Research, 2*(1), 135-153.

Ahlmeyer, S., Kleinsasser, D., Stoner, J., & Retzlaff, P. (2003). Psychopathology of incarcerated sex offenders. *Journal of Personality Disorders, 17(*4), 306-318.

Alish, Y., Birger, M., Manor, N., Kertzman, S., Zerzion, M., Kotler, M., & Strous, R.D. (2007). Schizophrenia sex offenders: A clinical and epidemiological comparison study. International *Journal of Law and Psychiatry, 30*(6), 459-466.

Alvarez, W.A., & Freinhar, J.P. (1991). A prevalence study of bestiality in-

psychiatric patients, medical in-patients and psychiatric staff. *International Journal of Psychosomatics, 38*(1), 45-47.

Baker, M., & White, T. (2002). Sex offenders in high-security care in Scotland. *The Journal of Forensic Psychiatry, 13*(2), 285-297.

Bauer, M.W. (2000). Classical content analysis: A review. In M.W. Bauer, & G. Gaskell (Eds.), *Qualitative research with text, image and sound: A practical handbook* (pp. 131-151). London: Sage.

Beck, A. T. (1963).Thinking and depression: 1. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9,* 324-333.

Beech, A. R., Parratt, N., Ward, T., & Fisher, D. (2009). Assessing female sexual offenders' motivations and cognitions: An exploratory study. *Psychology, Crime, & Law, 15*(2), 201-216.

Beggs, S.M., & Grace, R.C. (2008). Psychopathy, intelligence and recidivism in child molesters: Evidence of an interaction effect. *Criminal Justice & Behaviour, 35*(6), 683-695.

Benjamin, L.S. (1993). *Interpersonal diagnosis and the treatment of personality disorders.* New York: Guilford.

Berg, C.A., & Sternberg, R.J. (1988). Adults' conceptions of intelligence across the adult life span. *Psychology & Aging, 7*, 221-231.

Birtchnell, J., & Shine, J. (2000). Personality disorders and the interpersonal octagon. *British Journal of Medical Psychology, 73,* 433-448.

Blumenthal, S., Gudjonsson, G., & Burns, J. (1999). Cognitive distortions and blame attribution in sex offenders against adults and children. *Child Abuse & Neglect, 23*(2), 129-143.

Bogaerts, S., Declercq, F., Vanheule, S., & Palmans, V. (2005). Interpersonal factors and personality disorders as discriminators between intra-familial and extra-familial child molesters. *International Journal of Offender Therapy and Comparative Criminology, 49,* 48-62.

Bogaerts, S., Vanheule, S., & Desmet, M. (2006). Personality disorders and romantic adult attachment: A comparison of secure and insecure attached child molesters. *International Journal of Offender Therapy and Comparative Criminology, 50*(2), 139-147.

Bogaerts, S., Vervaeke, G., & Goethals, J. (2004). A comparison of relational attitude and personality disorders in the explanation of paedophilia. *Sexual Abuse: A Journal of Research and Treatment, 16*, 37-47.

Brennan, K.A., & Shaver, P.R. (1998). Attachment styles and personality disorders: Their connections to each other and to parental divorce, parental death, and perceptions of parental caregiving. *Journal of Personality, 66,* 835-878.

Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scale. Sexual Abuse: *A Journal of Research and Treatment, 8*, 37-54.

Burn, M.F., & Brown, S. (2006). A review of the cognitive distortions in child sex offenders: An examination of the motivations and mechanisms that underlie the justification for abuse. *Aggression and Violent Behaviour, 11*(1), 225-236.

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices. *The British Journal of Psychiatry, 166*(1), 773-776.

Chan, D.W., & Chan, L. (1999). Implicit theories of creativity: Teachers' perception of student characteristics in Hong Kong. *Creativity Research Journal. 12*(3), 185-195.

Chesterman, P., & Sahota, K. (1998). Mentally ill sex offenders in a regional secure unit. 1: Psychopathology and motivation. *Journal of Forensic Psychiatry, 9*(1),

150-160.

Chiswick, D. (1983). Sex crimes. *British Journal of Psychiatry, 143*, 236-242.

Cohen, L.J., & Galynker, I.I. (2002). Clinical features of paedophilia and implications for treatment. *Journal of Psychiatric Practice, 8*, 276-289.

Coid, J., Kathan, N., Gault, S., Cook, A., & Jarman, B. (2001). Medium secure forensic psychiatric services. *British Journal of Psychiatry, 178*, 55 – 61.

Craissati, J., & Hodes, P. (1992). Mentally ill sex offenders: The experience of a regional secure unit. *British Journal of Psychiatry, 161*(1), 846-849.

Craissati, J., Webb, L., & Keen, S. (2008). The relationship between developmental variables, personality disorders, and risk in sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 20*(2), 119-138.

Dawson, D.L., Barnes-Holmes, D., Gresswell, D. M., Hart, A.J., & Gore, N.J. (2009). Assessing the Implicit Beliefs of Sexual Offenders Using the Implicit Relational Assessment Procedure. *Sexual Abuse: A Journal of Research and Treatment, 21*(1), *57-75*

Denzin, N., & Lincoln, Y. (2000). *Handbook of qualitative research***.** Thousand Oaks, CA: Sage.

Dietz, P.E. (1992). Mentally disordered offenders. *Psychiatric Clinics of North America, 15,* 539-551.

Drake, C.R., & Pathe, M. (2004). Understanding sexual offending in schizophrenia. *Criminal Behaviour and Mental Health, 14*(1), 108-120.

Drake, C.R., Ward, T., Nathan, P., & Lee, J.K.P. (2001). Challenging the cognitive distortions of child molesters: An implicit theory approach. *The Journal of Sexual Aggression, 7*(1), 25-40.

Dweck, C. S., Chiu, C., & Hong, Y. (1995). Implicit theories and their role in judgements and reactions: A world from two perspectives. *Psychological Inquiry*, *6*(4), 267-285.

Dweck, C.S., & Elliott, E.S. (1983). Achievement motivation. In E.M. Hetherington (Ed.), *Handbook of child psychology: Socialization, personality, and social development* (4th ed.). New York: Wiley.

Edwards, J., Steed, P., & Murray, K. (2002). Clinical and forensic outcome 2 years and 5 years after admission to a medium secure unit. J*ournal of Forensic Psychiatry, 13*, 68 – 87.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.

Fliess, J.L. (1981). *Statistical methods for rates and proportions*. New York: Wiley.

Freeman, A., Pretzer, J., Fleming, B., & Simon, K. M. (1990). *Clinical applications of cognitive therapy*. New York: Plenum Press.

Gannon, T. A., Keown, K., & Rose, M.R. (2009). An examination of current psychometric assessments of child molesters' offence-supportive beliefs using Ward's implicit theories. *International Journal of Offender Therapy and Comparative Criminology, 53*(3), 316-333.

Gannon, T. A., & Polaschek, D.L.L. (2006). Cognitive distortions in child molesters: A re-examination of key theories and research. *Clinical Psychology Review, 26*, 1000-1019.

Gannon, T.A., Ward, T., & Collie, R. (2007). Cognitive distortions in child molesters: Theoretical and research developments over the past two decades. *Aggression and Violent Behaviour, 12*(4), 402-416.

Gannon, T.A, Ward, T., & Polaschek, D.L.L. (2004). *Child sexual offenders*. *Violence in society: New Zealand perspectives*. Christchurch: Te Awata Press.

Gannon, T.A. Wright, D.B., Beech, A.R., & Williams, S.E. (2006). Do child molesters

hold distorted beliefs? What does their memory recall tell us? *Journal of Sexual Aggression, 12*, 5-18.

Gopnik, A., & Meltzoff, A.N. (1997). *Words, thoughts and theories*. Cambridge, MA: MIT Press.

Gopnik, A., & Wellman, A.N. (1994). The theory theory. In L. A. Hirschfeld, & S. A. Gelman (Eds.), *Mapping the mind: Domain specificity in cognition and culture* (pp. 257–293). New York: Cambridge University Press.

Gore, D.K. (1988). *Measuring the cognitive distortions of child molesters: Psychometric properties of the cognition scale*. Unpublished doctoral thesis, Georgia State University. Atlanta, GA.

Greenall, P.V., & Jellico-Jones, L. (2007). Themes and risk of sexual violence among the mentally ill: Implications for understanding and treatment. *Sexual and Relationship Therapy, 22*(3), 323-337.

Greenhalgh, T., & Taylor, R. (1997). How to read a paper: Papers that go beyond numbers (qualitative research). *British Medical Journal, 315, 7*40–743.

Groth, A. N. (1979). *Men who rape: The psychology of the offender*. New York: Plenum Press

Hall, G. C. N. (1990). Prediction of sexual aggression. *Clinical Psychology Review, 10*, 229-245

Hall, G.C.N., & Hirschman, R. (1992). Sexual aggression against children: A conceptual perspective of etiology. *Criminal Justice and Behaviour, 19*(1), 8-23.

Hanson, R.K., & Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 86*, 348-362.

Hanson, R.K., Gizzarelli, R., & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and acceptance of sex with children. *Criminal Justice and*

Behaviour, 21(1)*,* 187-202.

Hanson, R.K., & Morton-Bourton, K.E. (2005). The characteristics of persistent offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

Hartley, C.C. (1998). How incest offenders overcome internal inhibitions through the use of cognitions and cognitive distortions*. Journal of Interpersonal Violence, 13,* 25-39.

Hartley, C.C. (2001). Incest offenders' perceptions of their motives to sexually offend within their past and current life context. *Journal of Interpersonal Violence, 16*, 459-475.

Hayashino, D.S., Wurtele, S.K., & Klebe, K.J. (1995). Child molesters: An examination of cognitive factors. *Journal of Interpersonal Violence, 10*(1), 106-116.

Horley, J. (2000). Cognitions supportive of child molestation. *Aggressive and Violent Behaviour, 5,* 551-564.

Howitt, D. (1995). *Paedophiles and sexual offences against children.* New York: John Wiley.

Jamieson, S., & Marshall, W.L. (2000). Attachment styles and violence in child molesters. *The Journal of Sexual Aggression, 5*(1), 88-98.

Jones, E.E. (1996). Introduction to the special section on attachment and psychopathology: Part 1. *Journal of Consulting and Clinical Psychology, 64*, 5-7.

Jones, G., Huckele, P., & Tanaghow, A. (1992). Command hallucinations, schizophrenia and sexual assault. *Irish Journal of Psychological Medicine, 9*(1), 47-49.

Kafka, M.P., & Hennen, J. (2002). A DSM-IV axis 1 comorbidity of males with

paraphilia and paraphilia-related disorders. *Sex Abuse, 14,* 349-366.

Kaplan, M. S., Abel, G. G., Cunningham-Rathner, J., & Mittelman, M. S. (1990). The impact of parolees' perception of confidentiality of their self-reported sex crimes. *Annals of Sex Research, 3*, 293-303.

Kennedy, H. G., & Grubin, D. H. (1992). Patterns of denial in sex offenders. P*sychological Medicine*, *22*(2), 191-196.

Kirk, J., & Miller, M. (1985). *Reliability and validity in qualitative research*. California: Sage Publications.

Krippendorff, (2004). *Content analysis: A flexible methodology.* New York: Plenum Press.

Langton, C. M., & Marshall, W. L. (2000). The role of cognitive distortions in relapse prevention programs. In R. D. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 167 – 186). Thousand Oaks, CA: Sage Publications.

Langton, C.M., & Marshall, W.L. (2001). Cognition in rapists: Theoretical patterns by typological breakdown. *Aggression and Violent Behaviour, 6*(5), 499-518

Lehne, G. (2002). The Neo-PI and the MCMI in the forensic evaluation of sex offenders. In P. Costa, & T. Widiger (Eds.), *Personality disorders and the five factor model of personality* (pp. 175-188). Washington, DC: American Psychological Association.

Levy, S.R., Stroessner, S.J., & Dweck, C.S. (1998). Stereotype formation and endorsement: The role of implicit theories. *Journal of Personality & Social Psychology, 74*(6), 1421-1436.

Lincoln, Y.S., & Guba, G.E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage

Malamuth, N.M., & Brown, L.M. (1994). Sexually aggressive men's perceptions of women's communications: Testing three explanations. *Journal of Personality and Social Psychology, 67*(1), 699-712.

Malamuth, N.M., Sockloskie, R., Koss, M.P., & Tanaka, J. (1991). The characteristics of aggressors against women: Testing a model using a national sample of college students. *Journal of Consulting and Clinical Psychology, 59*(2), 670-681.

Mann, R.E., & Beech, A.R. (2003). Cognitive distortions, schemas and implicit theories. In T. Ward, D.R. Laws, & S.M. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp. 135-153). London: Sage Publications.

Mann, R.E., & Hollin, C.R. (2001, November). *Schemas: A model for understanding cognition in sexual offending.* Paper presented at the Annual Research & Treatment Conference, Association for the Treatment for Sexual Abusers, San Antonio.

Marshall, W.L. (1996). Assessment, treatment and theorising about sexual offenders: Developments over the past 20 years and future directions. *Criminal Justice and Behaviour, 23,* 162-199.

Marshall, W. L., & Barbaree, H. E. (1990). An integrated theory of the aetiology of sexual offending. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 257-275). New York: Plenum Press.

Marshall, W.L., Hamilton, K., & Fernandez, Y. (2001). Empathy deficits and cognitive distortions in child molesters. *Sexual Abuse: A Journal of Research and Treatment, 13*(2), 123-130.

Marziano, V., Ward, T., Beech, A.R., & Pattison, P. (2006). Identification of five fundamental implicit theories underlying cognitive distortions in child abusers: A preliminary study. *Psychology, Crime and the Law, 12*(1), 97-105.

Mason, J. (2002). *Qualitative researching*. London: Sage.

McConnell, A.R. (2001). Implicit theories: Consequences for social judgments of

individuals. *Journal of Experimental Social Psychology, 37*(3), 215-227.

Mihailides, S, Devilly, G.J., & Ward, T. (2004). Implicit cognitive distortions and sexual offending. *Sexual Abuse: A Journal of Research and Treatment, 16*, 333-350.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative Data Analysis*. London: Sage.

Millon, T. (1996). *Disorders of personality.* New York: Wiley.

Milner, R.J., & Webster, S.D. (2005). Identifying schemas in child molesters, rapists, and violent offenders. *Sexual Abuse: A Journal of Research and Treatment, 17*, 425-439.

Morse, J.M., Barratt, M., Mayan, M, Olson, K., & Spiers, J. (2001). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1,* 11–23.

Moulden, H.M., & Firestone, P. (2007). Vicarious traumatization: The impact on therapists who work with sexual offenders. *Trauma, Violence, & Abuse, 8*(1), 67-83

Murphy, W. D. (1990). Assessment and modification of cognitive distortions in sex offenders. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 331-340). New York: Plenum Press.

Murray, K., Briggs, A., & Davies, A. (1994). Psychopathic disordered, mentally ill and mentally handicapped offenders: A comparison study. *Medicine, Science and The Law, 32*(2), 331-334.

Myers, R. (2000). *Identifying schemas in child and adult sex offenders and violent offenders*. Unpublished mater's thesis, University of Leicester.

Neale, J. (2009). *Research methods for health and social care*. London: Palgrave

Macmillan

Neidigh, L., & Krop, H. (1992). Cognitive distortions among child sexual offenders. *Journal of Sex Education and Therapy, 18*(3), 208-215.

Neuendorf, K. (2002). *The content analysis guidebook*. Thousand Oaks, CA: Sage.

Nunes, K.L., Firestone, P., & Baldwin, M.W. (2007). Indirect assessment of cognitions of child sexual abusers with the implicit association test. *Criminal Justice and Behavious, 34*(4), 454-475.

Packard, W.S., & Rosner, R. (1985). Psychiatric evaluations of sexual offenders. *Journal of Forensic Sciences, 30,* 715-720.

Patton, M.Q. (2002). *Qualitative research and evaluative methods*. Thousand Oaks, CA: Sage.

Philips, S.L., Heads, T.C., Taylor, P.J., & Hill, G.M. (1999). Sexual offending and

antisocial sexual behaviour among patients with schizophrenia. *Journal of Clinical Psychiatry, 60,* 170-175.

Polaschek, D.L.L., Calvert, S., & Gannon, T.A. (2009). Linking violent thinking: Implicit theory based research with violent offenders. *Journal of Interpersonal Violence*, *24*(1), 75-96.

Polaschek, D.L.L., & Gannon, T.A. (2004). The implicit theories of rapists: What convicted offenders tell us. *Sexual Abuse: A Journal of Research and Treatment*, *16*(1), 299-313.

Pollack, N.L., & Hashmall, J.M. (1991). The excuses of child molesters. *Behavioural Sciences and the Law, 9*(1), 53-59.

Proeve, M., & Howells, K.H. (2006). Shame and guilt in child molesters. In W.L. Marshall, Y.M. Fernandez, L.E. Marshall, & G.A. Serran (Eds.), *Sexual offender treatment: Controversial issues* (pp. 125-139). Chichester: John Wiley & Sons.

Puccio, G.J., & Chimento, M.D. (2001). Implicit theories of creativity: Laypersons' perceptions of the creativity of adaptors and innovators. *Perceptual & Motor Skills, 92*(3), 675-681.

Quayle, E., Holland, G., Linehan, C., & Taylor, M. (2000). The internet and offending behaviour: A case study. *The Journal of Sexual Aggression, 6*, 78-96.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of consulting psychology, 21,* 95–103.

Runco, M.A., & Johnson, D.J. (2002). Parents' and teachers' implicit theories of children's creativity: A cross-cultural perspective. *Creativity Research Journal, 14*(3-4), 427-438

Sahota, K., & Chesterman, P. (1998). Sexual offending in the context of mental illness. *Journal of Forensic Psychiatry, 9*(2), 267-280.

Salter, A. C. (1988). Treating *child sex offenders and victims: A practical guide*. Beverly Hills, CA: Sage.

Saradjian, A., & Nobus, D. (2003). Cognitive distortions of religious professionals who sexually abuse children. *Journal of Interpersonal Violence, 18,* 905−923.

Seale, C. (1999). *The quality of qualitative research*. Oxford: Blackwell.

Seto, M.C., & Barbaree, H.E. (1999). Psychopathy, treatment behaviour, and sex offender recidivism. *Journal of Interpersonal Violence, 14*, 1235-1248.

Sheppard, M. (2004). *Appraising and using social research in the human services: An introduction for social work and health professionals*. London: Jessica Kingsley Publishers.

Silverman, D. (2000). *Doing qualitative research: A practical handbook*. London: Sage.

Smallbone, S.W., & Dadds, M.R. (2000). Attachment and coercive sexual behaviour. *Sexual Abuse: A Journal of Research and Treatment, 12,* 3-15.

Smith, A. (1999). Aggressive sexual fantasy in men with schizophrenia who commit contact sexual offences against women. *Journal of Forensic Psychiatry, 10*(3), 538-552.

Smith, A. (2000). Motivation and psychosis in schizophrenic men who sexually assault women. *Journal of Forensic Psychiatry, 11*(1), 62-73.

Smith, A.D., & Taylor, P.J. (1999). Social and sexual functioning in schizophrenic men who commit serious sex offences against women. *Criminal Behaviour and Mental Health, 9*(1), 156-167.

Stermac, L.E., & Segal, Z.V. (1989). Adult sexual contact with children. An examination of cognitive factors. *Behavioural Therapy, 20*(1), 573-579.

Stermac, L.E., Segal, Z.V., & Gillis, R. (1990). Social and cultural factors in sexual assault. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 143-160). New York: Plenum.

Sternberg, R.L., Conway, B.E., Ketron, J.L., & Bernstein, M. (1981). People's conceptions of intelligence. *Journal of Personality and Social Psychology, 41*, 37-55.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage Publications.

Thakker, J., Ward, T., & Navathe, S. (2007). The cognitive distortions and implicit theories of child sexual abusers. In T.A. Gannon, T. Ward, A.R. Beech, & D. Fisher (Eds.), *Aggressive offenders' cognition: Theory, research and practice*. Wiley.

Thornton, D., & Schingler, J. (2001). *The impact of schema level work on sexual*

offenders' cognitive distortions. Paper presented at the 20th Annual Research and Treatment Conference for the Treatment of Sexual Abusers, San Antonio, USA.

Towns, A. J., Singh, N.N., & Beale, I. L. (1984). Reliability of observations in a double- and single-blind drug study: An experimental analysis. *Advances in Learning and Behavioural Disabilities*, *3(*2), 15-240.

Wallace, C., Mullen, P.E., Burgess, P., Palmer, S., Ruschena, D., & Browne, C. (1998). Serious criminal offending and mental disorder. *British Journal of Psychiatry, 172*(2), 477-484.

Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories. *Aggression and Violent Behaviour, 5*(5), 491-507.

Ward, T., Fon, C., Hudson, S. M., & McCormack, J. (1998). A descriptive model of dysfunctional cognitions in child molesters. *Journal of Interpersonal Violence*, *13*, 129-155.

Ward, T., Hudson, S. M., & France, K. G. (1993). Self-reported reasons for offending behaviour in child molesters. *Annals of Sex Research*, *6*, 139-148.

Ward, T., Hudson, S. M., Johnston, L., & Marshall, W. L. (1997). Cognitive distortions in sex offenders: An integrative review. *Clinical Psychology Review*, *17*, 479-507.

Ward, T., Hudson, S. M., & Marshall, W. L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist interpretation. *Sexual Abuse: A Journal of Research and Treatment*, *7*(1), 67-83.

Ward, T., & Keenan, T. (1999). Child molesters' implicit theories. *Journal of Interpersonal Violence*, *14*, 821-838.

Ward, T., Keenan, T., & Hudson, S.M. (2000). Understanding cognitive, affective and intimacy deficits in sexual offenders: *A developmental perspective. Aggression and Violent Behaviour, 5*(1), 41-62.

Ward, T., Louden, K., Hudson, S. M., & Marshall, W. L. (1995). A descriptive model of the offence chain for child molesters. *Journal of Interpersonal Violence*, *10*(4), 452-472

Ward, T., McCormack, J., & Hudson, S.M. (1997). Sexual offenders' perceptions of their intimate relationships. Sexual Abuse: A Journal of Research and Treatment, 9, 57-73.

Ward, T., Nathan, P., Drake, C.R., Lee, K.P., & Michele, P. (2000). The role of formulation-based treatment for sexual offenders. *Behavioural Change, 17*, 251-264.

Ward, T., & Siegert, R. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, & Law, 8*(1), 319-351.

Weber, R.P. (1990). *Basic content analysis*. Newbury Park, CA: Sage

Willig, C. (2001*). Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, UK: Open University Press.

Young, J. E. (1990). *Cognitive therapy for personality disorders: A schema focused approach.* Sarasota, FL: Professional Resource Press.

Appendix A: Semi Structured Interview Protocol

Nottinghamshire Healthcare NHS
NHS Trust
Positive about mental health and learning disability

Introduction:

My name is Karyn Mannix and I would like to thank you for deciding to take part in my research project. Today I will be conducting an interview with you. As stated on the Participant Information sheet the information you tell me will not be traceable back to you because I am going to use a coding system. Also, all the information will be kept in a secure and locked cabinet in the department. I will be taping the interview which will be listened to by myself and an administrative secretary in this hospital. Other researchers, my university supervisors, will review the information form the coded and transcribed interview but not from the tape itself. Do you still give your consent to be audio-taped?

I need to remind you that, as was stated on both the Participation Information Sheet and the Consent Form, you can withdraw from the research at any time. So, before we start, do you have any questions?

Now I am going to ask you some questions about your (index) offence. All that I would like you to do is to answer the questions as honestly as possibly. I would like you to think back to the time of your offending. It's important that you place yourself back to just prior to when you offended. Take a few moments to place yourself there in your mind.

I will start the tape recording now.

Q1: Can you briefly describe to me what your life was like at the time of your (Index) offence?

Were you experiencing any difficulties with your personal relationships? Work? Friendships?

How did you experience other people (your partner, etc) at the time? Feelings at the time?

What made it hard to make friends or have a close relationship? (if applicable)

What did you do to cope with these problems?

Q2: Walk me through the day of your offence. Give me an overview of what happened that day, from the time you got up in the morning until the time after the offence?

When did you notice yourself thinking about the child?

What were you experiencing at that time? How did you make sense of that?

When did you start thinking about sexually offending?

When you had sexual thoughts at that time, how did it make you feel? (positive or negative)

How strong were the urges to offend for you?

What do you think caused this urge, or pushed it along?

What did you do to cope with these urges? If anything.

How did you view yourself at that time? (positive or negative)

What did you tell yourself to proceed with the offending?

Can you tell me how you went from thinking about the child to deciding to make contact? What did you tell yourself at the time to make you want to continue?

What was it about this particular child that made you want to have contact with him / her?

Did the child do/say anything prior to contact? How did you interpret that?

How did you view yourself, and what was happening?

How did child react at the time before the offence?

How did the child seem during the offence? (compliant, willing, resistive, quiet)

What do you think was going on for the child during the offence?

What were you experiencing at this time? (negative or positive)

How did the child react after the offence? (negative or positive)

How did you feel about what happened following the offence?

Q3: Can you briefly describe to me what you were experiencing (thoughts and feelings) in the time after the offence and the weeks following?

What did you say to yourself afterwards?

How did you view yourself after the offence?

How did you view the child after the offence?

How did you act towards the child following the offence?

How did you feel following the offence?

What role do you think the child had in your offending?

How serious do you think your offending was?

How harmful was your offending to the child? In what ways?

Looking back at it, how do you make sense of your offending?

Is there anyone else that you feel is responsible, or partly responsible for your offending?

Appendix B: Audio Recording Consent Form

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Audio Recording Consent Form

I _____ of _____ consent to being audio taped.

I understand that any resulting recording will be anonymised and used for Research and that the information I provide will be seen by those involved in the research (e.g. the Researcher, the Researcher's academic supervisor) and a wider audience if published in an academic journal.

I understand that the resulting recording may be listened to on more than one occasion but will be destroyed after it has been used for the purpose I have agreed to (e.g. once the interview has been transcribed). Furthermore, I understand that the audio-tape and any transcribed transcript will be destroyed up to 1 month after the interview should I change my mind and withdraw consent.

I understand the responsibility for following the above procedures will be with the Researcher, Karyn Mannix, and that Nottinghamshire Healthcare NHS Trust holds the copyright of the audio recorded material.

I agree to a copy of this consent form to be placed on the Clinical File and the original to be retained with the recording.

Signed _____ Signed _____

(Participant) (Researcher)

Date _____ Date _____

Signed _____

(Responsible Clinician)

Date _____

Consent Withdrawn

Signed _____ Date _____

Appendix C: Responsible Clinician Information Sheet

Nottinghamshire Healthcare NHS
NHS Trust
Positive about mental health and learning disability

RC Information Sheet

***Study Title*: Implicit Theories in High Secure Male Child Sexual Offenders with a Mental Disorder**

***Investigator:* Karyn Mannix**

You are being asked to give consent for patients under your care to be invited to participate in a research study. Before you decide it is important you know why the study is being done and what it will involve for participants. Please take time to read the following information. If any aspect of the study is unclear please ask for more information.

What is the purpose of the study?

Cognitive distortions (e.g. justifying or excusing sexually abusive behaviour) which play an important role in facilitating sexual offending, are generated by structures called Implicit Theories (ITs). ITs guide sexual offenders' own interpretations and decisions about behavior, and are used to predict the intentions behind other people's behaviors. There is evidence that child sexual offenders have a number of distinct ITs that underlie the distorted cognitions they have about children. These are (1) Nature of Harm (2) Children as sexual objects (3) Male sex drive is uncontrollable (4) Dangerous world and (5) Entitlement. Little is known about the ITs held by child sex offenders with a mental disorder. Thus, this study aims to identify whether the ITs present in child sex offenders will be present in child sexual offenders with a mental disorder.

Why have I been approached to give consent for patients under my care to be invited to participate in a research study?

You have been approached because you are the RC for patients in one of the directorates involved in this study; the _ Directorate and the _ Directorate. Consequently, there are patients under your care who meet the criteria for this research study. Inclusion criteria for this study are:

(i) A clinical diagnosis of mental illness and/or personality disorder
(ii) A contact sexual offence against a child (e.g. rape or attempted rape).

Exclusion criteria include:

(i) Patients who RC does not feel they are able to provide informed consent
(ii) Patients who refuse consent to be interviewed/recorded
(iii) Patients who are floridly psychotic impacting upon their ability to give consent and/or to be interviewed
(iv) Patients who have committed sexual offences against adult victims only.
(vii) Patients who do not speak English fluently

What will be required of patients who participate in the study?

Once you have given consent for patients to be invited to participate (See consent form attached), they will be given an information sheet informing them about the nature and aims of the study, and what their participation is likely to entail. They will also be given a consent form which they will be asked to sign and return to the researcher if they decide to participate.

Once patients have returned the signed consent forms, the researcher will organise a time to meet them individually to conduct a semi-structured interview. Interviews will be conducted in the interview room on each participant's ward. This will contain structured questions, which will focus on the patient's life situation at the time prior to their offending and ask them about their thoughts, feelings and beliefs before, during and after their offence.

Completing the interview is estimated to take approximately 90 minutes and it will be audio-taped. Participants will be briefed on the rationale for recording the interview and asked to sign the NHS Trust policy consent form before the interview is commenced.

After the interview the researcher will look at patients' ward file to note details of their age, diagnosis, current medication, if any, Mental Health Act Classification and Mental Health Act Section and their offences only.

Do patients have to take part?

No. It is up to each patient to decide whether or not they wish to participate in the study. They are not under any obligation to take part in the study.

What are the possible disadvantages or risks for patients taking part in the study?

Participation will not lead to any changes in patients' care plan or treatment. The interview will take up to 90 minutes of their time but if a patient agrees to take part, the researcher will arrange to meet with them at a time convenient for them so that taking part in the study does not interfere with their other activities.

Talking about their offence history is a sensitive subject. If the researcher thinks that the interview is having a negative effect on a participant's mental health, the interview be will terminated and the participant will be given the opportunity to speak with the researcher or a member of nursing staff.

At the end of each interview the researcher will ask the participant if the interview has brought back any memories or feelings that they are finding difficult to cope with. If this is the case, the researcher will ask for permission to inform a member of their clinical team.

What are the possible advantages of patients taking part in the study?

Patient participation will be helpful to the researcher, professionals and other patients in the future. Advances in care and treatment in the NHS have been made possible by the participation of volunteers in research studies. By understanding the complexity of the interaction between mental illness and sexual offending, as well as the complexity of offenders' cognitions exhibited during treatment, the role of implicit theories to the entire offending process will be highlighted. Construing cognitive factors in this manner may assist in the reduction of sexual offending against children.

What happens if patients don't agree to take part?

If patients do not wish to take part in the study it is not a problem. Their care and treatment will not be affected and their legal rights will not be altered in any way.

What if patients agree to take part and then change their mind?

If a patient decides to withdraw from the study, their treatment will not be affected nor will they be penalized in any way. Any information they have provided will be destroyed, provided they withdraw within 1 month from the time of participation. However, if participants change their mind after 1 month of being interviewed, their information will continue to be used in the study.

What will happen to the information patients provide and will it be confidential?

Information provided by participants will not become part of their clinical record. Tapes will be stored safely in a locked cabinet until transcribed, following which they will be destroyed. Participants' interview transcripts will be anonymised and stored using just an identifying number (this will ***not*** be their patient number, date of birth or anything that could identify them). All transcripts will be stored safely in a locked filing cabinet. This information will also be anonymous so that it will not be possible for anyone other than the researcher to identify which information belongs to which patient.

What will happen to the results of the study?

When the research stops the results of the study will be written up and used as the basis for her Clinical Psychology Doctorate at the University of Lincoln. In the future she would like to publish the study, and present the information to other professionals. An information sheet explaining the results of the study will be made available to you and participants if requested.

What do I do if I want to make a complaint about the Study?

There is a complaints procedure available to you through Nottinghamshire Healthcare NHS Trust. If you are unhappy about any aspect of the study please contact the researcher via the address below.

What do I do now?

Please read the list of patients under your care who have been identified as meeting the inclusion criteria. If you agree for these patients to be invited to participate, fill in both the participation and audio recording consent forms for each named patient and send it to Karyn Mannix (Hospital Address).

Thank you for your time.

Contact for further information:

If you would like further information about the study or have any questions about the study please contact: Karyn Mannix, Trainee Clinical Psychologist, Department of Psychology, Ext. ___.

Appendix D: Responsible Clinician Consent Form

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

RC Consent Form

***Study Title*: Implicit Theories in High Secure Male Child Sexual Offenders with a Mental Disorder**

***Name of Researcher*: Karyn Mannix**

Patient Name:

Please tick box

1. I confirm that I have read and understand the information sheet dated September 2008 for the above study and have had the opportunity to ask questions ☐

2. I understand that the above named patient's participation is voluntary and that they are free to withdraw at any time, without giving any reason, without their medical/ psychological care or legal rights being affected. ☐

3. I understand that sections of the above named patient's medical notes may be looked at by the researcher (Karyn Mannix) where it is relevant to the research. I give permission for this individual to have access to the relevant records. ☐

4. Is this individual currently experiencing an active psychosis that would impact upon his ability to be interviewed? **Y/N**

5. In your opinion would it be in this patient's best interest NOT to participate? **Y/N**

6. I agree for the researcher to invite the above named patient to participate in the research study described ☐

_____	_____	_____
Name of Responsible Clinician	Date	Signature

1 for RC; 1 for researcher; 1 to be kept with hospital notes

Appendix E: Participant Information Sheet

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Participant Information Sheet

***Study Title*: Implicit Theories in High Secure Male Child Sexual Offenders with a Mental Disorder**

***Investigator:* Karyn Mannix**

You are being invited to take part in a research study. Before you decide whether you wish to take part or not it is important you know why the study is being done and what it will involve. Please take time to read the following information. You may wish to discuss it with other people (e.g. your Named Nurse). If any aspect of the study is unclear please ask for more information. Take as much time as you wish to decide whether or not you wish to take part.

What is the purpose of the study?

Research suggests that men who commit sexual offences against a child see and think about themselves, their victim and their offending in ways that facilitate and maintain their sexual offending behaviour. These have been called Implicit Theories. Research has identified 5 common implicit theories held by men without a mental disorder who have offended against children. This study will explore whether these 5 theories are evident in men who have a mental illness.

Why have I been invited to take part?

You have been invited to participate because

- You meet the criteria for the research
  - a patient in the _ / _ Directorate
  - a clinical diagnosis of Mental Illness and/or Personality Disorder
  - a contact sexual offence against a child

- Your Responsible Clinician (RC) has given consent for you to be invited to participate.

Other men in these directorates, who satisfy this criteria, will also be invited to participate in the study.

Do I have to take part?

No. It is up to you to decide whether or not you wish to take part in the study. This information sheet will describe the study and your role if you decide to participate. If you decide to take part, you will be asked to sign a consent form to show you have agreed to participate. You are free to withdraw at any time, without giving a reason. This will not affect the standard of care you receive.

What will I have to do if I agree to take part in the Study?

If you agree to take part, fill in your details on the last page of this information sheet and send it to the researcher via the hospital post - Karyn Mannix, Psychology Department.

The researcher will then contact you and arrange a convenient time to meet with you to conduct an interview. The interview will contain structured questions, which will focus on how your life was at the time prior to your offending. You will be asked to talk about the thoughts and feelings you had before, during and after your offence. This will help in developing an understanding of your offence.

Completing the interview will take approximately 1 hour and 30 minutes of your time. It will take place in a private interview room on your ward or villa. The interview will be audio-taped. This is necessary to allow for an accurate transcription of your interview data and to ensure that you are not misunderstood. You will be asked to sign a consent form to allow your interview to be recorded which is part of the NHS trust policy.

After the interview the researcher will look at your ward file to note details of your age, diagnosis, current medication, if any, Mental Health Act Classification and Mental Health Act Section and your offences only.

What are the possible disadvantages or risks of taking part in the study?

Taking part in the study will not lead to any changes in your care plan or treatment. The study will take up to a maximum of 90 minutes of your time but if you agree to take, the researcher will arrange to meet you at a time you are free so that your participation does not interfere with your other activities.

Talking about your offence history is a sensitive subject. If the researcher thinks that the interview is distressing you, she will stop the interview and give you the opportunity to speak about this with her or a member of your care team (e.g. your named nurse). At the end of the interview if the interview has brought back any memories or feelings that you are finding difficult to cope with, you will be given the opportunity to discuss this with the researcher or a member of your clinical team who you feel comfortable speaking to (e.g your named nurse / associate nurse). If you do not wish to discuss how you are feeling with anyone, the researcher will inform ward staff that you were involved in a sensitive

discussion regarding your offending history and ask them to support you with any distress if you request this at a later time.

What are the possible advantages of taking part in the study?

You will not receive preferential treatment in any way for taking part in the study. Your valuable time is appreciated as most advances in care and treatment in the NHS have been made possible by the participation of patients in research studies. However, I cannot promise the study will help you but the information gained from this study will help improve professionals' understanding of and treatment offered to men who offend sexually against children.

What happens if I don't agree to take part?

If you do not wish to take part in the study it is not a problem. Your care and treatment will not be affected and your legal rights will not be altered in any way.

What will happen to the information I provide and will it be confidential?

The information you give during the study will not become part of your clinical record.

No one other than the researcher and an administrative secretary working in the hospital will have access to your interview tape. This will be stored safely in a locked cabinet until it has transcribed it. When this is completed, the tape will be destroyed. Your interview transcript will be made anonymous – it will be stored using just an identifying number (this will ***not*** be your Patient number, date of birth or anything that could identify you).

All transcripts will be stored safely in a locked filing cabinet. It will not be possible for anyone other than the researcher to identify which information belongs to which participant. This information will also be anonymous so that no one can tell which information is from a particular person. This information will be retained for up to 5 years following the study as requested by NHS Trust policy and stored safely in a locked cabinet. After this time, the information will be destroyed.

What if I agree to take part and then change my mind?

If you withdraw from the study, please let me know. Withdrawal will not affect your treatment and you will not be penalized in any way. If you withdraw within one month of being interviewed, your information will not be used in the study. All your identifiable data will be destroyed. If you withdraw after one month of being interviewed, your information will continue to be used in the study.

What will happen to the results of the study?

An information sheet explaining the results of the study will be made available to you at the end of the study if you would like it. The researcher will use the results from the study as the basis for her Clinical Psychology Doctorate at the University of Lincoln. In the future she would like to publish the study, and present the information to other professionals. It will not be possible to identify any individual participants from the information presented.

What do I do if I want to make a complaint about the Study?

There is a complaints procedure available to you through Nottinghamshire Healthcare NHS Trust. Please speak to your Named Nurse or a member of Advocacy who will help you to

make a formal complaint. If you are unhappy about any aspect of the study please contact the researcher via the ____ Directorate (Ext ___).

What do I do now?

If you would like to take part or find out more about this study, please sign the consent form attached and send it to the address below. The researcher will contact your ward and arrange a date and time to conduct the interview that is convenient for you.

Thank you for your time.

Contact for further information:

If you would like further information about the study or have any questions about the study please ask ward staff to contact me on the number below and a meeting can be arranged to clarify any of your concerns: Karyn Mannix, Trainee Clinical Psychologist, Department of Psychology, Ext _____:

Appendix F: Participant Consent Form

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Patient Consent Form

***Study Title*: Implicit theories in High Secure Male Child Sexual Offenders with a Mental Disorder**

***Investigator:* Karyn Mannix**

I have read the participant information leaflet and understand that I do not have to take part in the study. If I decide that I do not wish to take part in the study my treatment will not be prejudiced by my decision. I understand that I can change my mind about taking part in the study at any time.

Please tick box

1. I confirm that I have read and understand the information sheet dated September 2008 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my care being affected. ☐

3. I understand that sections of any of my medical notes may be looked at where it is relevant to my taking part in research. I give permission for the researcher (Karyn Mannix) to have access to my records. ☐

4. I agree to take part in the above study. ☐

By signing this form I am agreeing for the information I give to be used in the study.

Name _____ Date:_____

Witness_____ Date:_____

Researcher_____ Date:_____

Please send me an information sheet explaining the results of this study ☐

1 for patient; 1 for researcher; 1 to be kept with hospital notes

Appendix G: Coding Frame

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Children as Sexual Beings Implicit Theory

Children both need and desire sex and are able to make informed decisions related to sexual behaviour.

Examples of supporting cognitive distortions:

"The child wanted sex"

"If they didn't want to do it they would have said no"

"The older one wanted to have sex with me"

"It was so he could relieve himself sexually you know"

Nature of Harm

Harm ranges from minor to severe and some sexual activity is harmless

Examples of supporting cognitive distortions:

"I didn't penetrate them so I wasn't really hurting them"

"Since I already done it, one more wouldn't make a difference"

"All I did was put my penis between her legs"

"I don't think I mentally hurt her".

Uncontrollability

Belief that the world is essentially uncontrollable and behaviour occurs based on factors out of one's direct control such as alcohol, drugs, depression, all coupled with the presence of a child leading the offender to 'lose control'.

Examples of supporting cognitive distortions:

"It was just a feeling at the time, I could not stop myself"

“The evil took over my life back then”

“It happened to me so this is what is supposed to happen”

“Once you have had one, you just want more and more and more”.

Entitlement

Belief that they are entitled to take sex if they wanted it because they are superior and simply more deserving of whatever they wanted

Examples of supporting cognitive distortions:

“I wanted something that belonged to me”

“I created her she is mine”

“It was just that the child made me feel better about myself”

“People shouldn’t be suppressed it’s like someone trying to deprogram someone his age”.

Dangerous World

Generalised hostility towards the world, where people are perceived as unreliable and untrustworthy. Children are safe and reliable.

Examples of supporting cognitive distortions:

“If I don’t let anyone in I’m not going to get hurt any further”

“I didn’t want to be controlled by anyone”

“I just didn’t want anything to do with adults, children are much safer”

“I was more interested in a younger group because they seemed to brighten up my life”.

Appendix H: Participant's Individual Coding Sheet

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Participant:

Implicit Theory	Please Tick If present	Examples of supporting cognitions
Children as Sexual Beings		
Nature of Harm		
Uncontrollability		
Dangerous World		
Entitlement		
Miscellaneous		